MEDICIAD 101+

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Michigan Association of Health Plans

MAHP: Who We Are

- The Michigan Association of Health Plans is a nonprofit corporation established to promote the interests of member health plans.
- MAHP's mission is "to provide leadership for the promotion and advocacy of high quality, accessible health care for the citizens of Michigan."
- Represents 10 health plans covering all of Michigan and more than 45 related business and affiliated organizations. Our member health plans employ about 8,000 persons throughout the state.
- Member health plans provide coverage for more than 3 million Michigan citizens – nearly one in every three Michiganders.
- Member health plans collect and use health care data, support the use of "evidence based medicine", and facilitate disease management and care coordination in order to provide cost-effective care.

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MAHP: Who We Are

MAHP Member Health Plans:

Aetna Better Health of Michigan 1,2,3

Health Alliance Plan 1,2,3

Molina Healthcare of Michigan 1,2,3

Physicians Health Plan 1,3

United Healthcare Community Plan 1,2,3

McLaren Health Plan 1,2,3

Meridian Health Plan / Michigan Complete Health 1,2,3

Paramount Care of Michigan 1,3

Priority Health / Total Health Care Plan 1,2,3

Upper Peninsula Health Plan 2,3

Key: 1 = Commercial Health Plan **2 = Medicaid Health Plan** **3 = Medicare Advantage or Medicare Special Needs Plan**

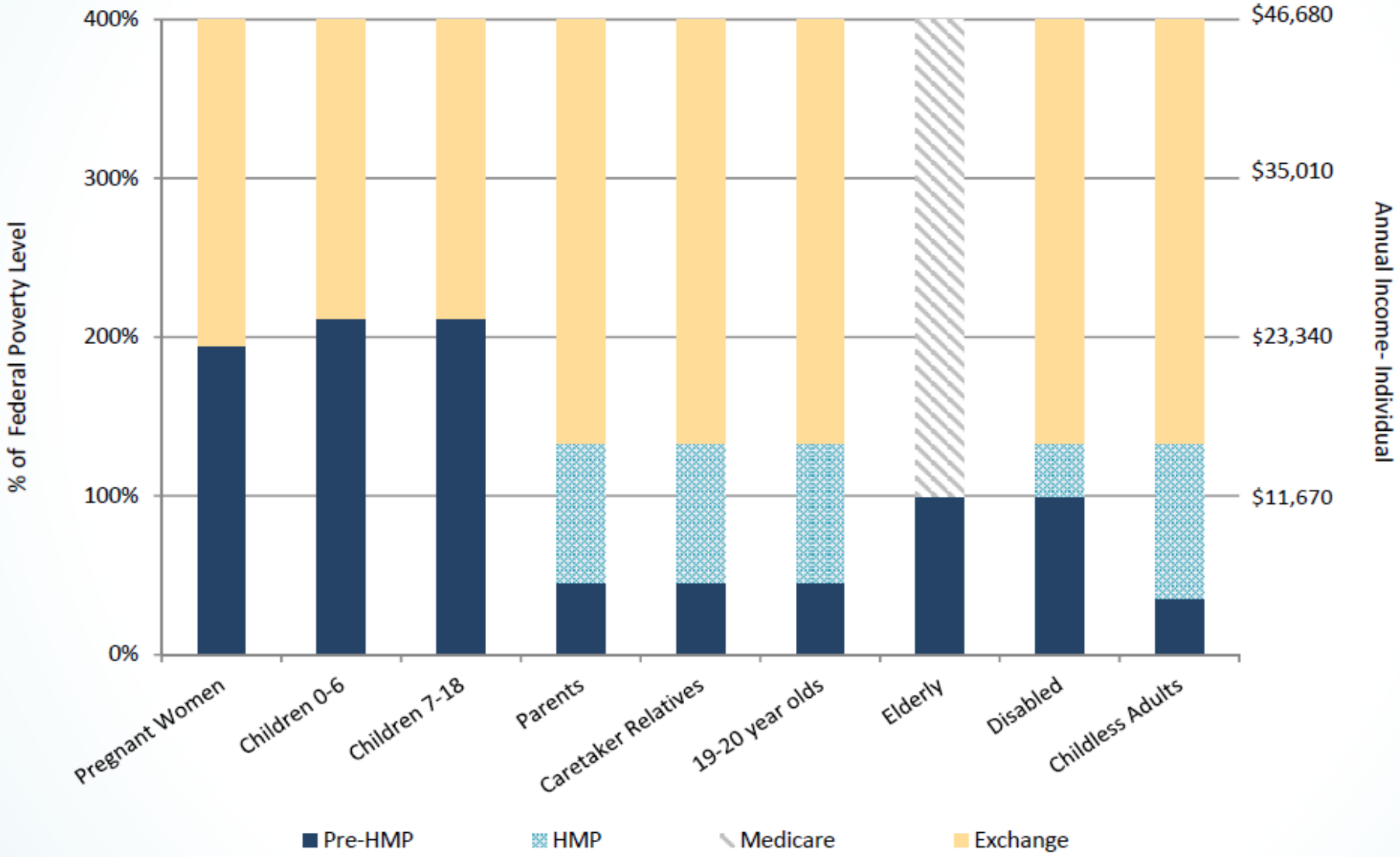
MAHP VISION

- ***MAHP members expand coverage access for Consumers. Michigan will provide should be a national leader in providing health insurance coverage options to the State's population.***

- ***Michigan's health insurance industry improves value, affordability, choice and competition. By fostering competition, Michigan will become one of the top 25 competitive states for health insurance.***

- ***MAHP members will advocate for the improved health status of Michigan consumers. MAHP members will work with partners in government, the provider community, community organizations, and business leaders to improve the health status of Michigan residents in areas that MAHP members serve through meaningful transparency and a focus on integrating benefits.***

Eligible Populations



Managed Care Beneficiaries have Choice of Plans

- Over 2/3 of new enrollees make a choice of their plan and about 1/3 of new monthly enrollment is due to Auto Assignments (when beneficiary does not make choice)
- Auto Assignment enrolls beneficiaries to health plans using performance based criteria
  - Quality Measures
  - Administrative measures
  - Access to Care measures

Medicaid Managed Care

COST

- **Medicaid services are managed and costs are predictable-** In FY20 alone managed care considerations for emergency room, inpatient hospital, pharmacy services and maternity case rates yielded a savings of $32.8 million.

ACCESS

- **Managed care provides greater access to care**
  - Robust Health Plan provider networks
  - No wait list for Medically necessary and clinically appropriate services
  - Provides structure that generates state savings and increases reimbursements to providers.

QUALITY

- **Smart Incentives built into Medicaid Contracts with private health plans**
  - Return on Investment (improved health status, access and costs savings)
  - HEDIS quality scores tracked and measured against commercial and Medicare benchmarks

COST - Prescription Drug Spending Growth Slower but Continues to Rise

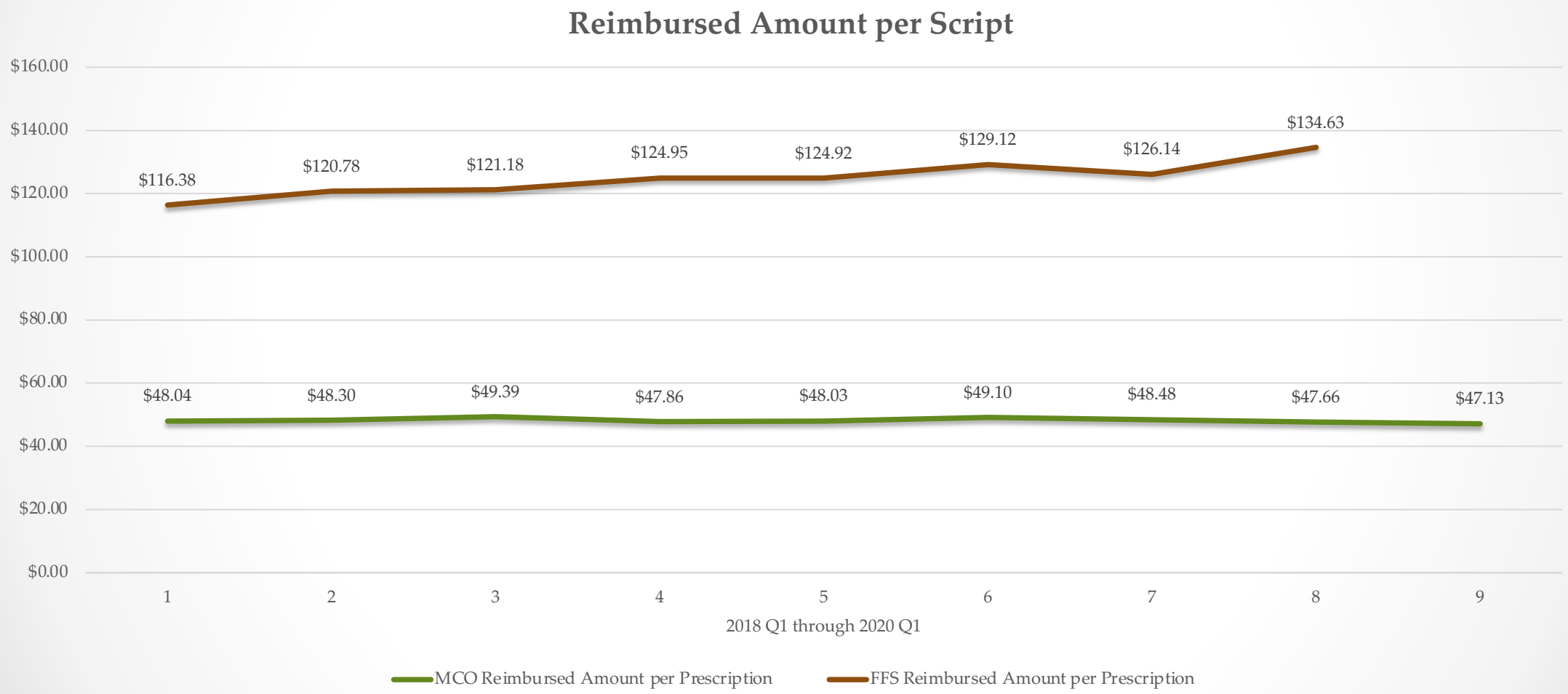
- **U.S. prescription net drugs spending rose to $509 billion in 2109. It has increased at a Cost Adjusted Growth Rate (CAGR) of 4.1% over the past five years. This net spending is calculated after supply chain discounts, manufacturer rebates, patient out-of-pocket costs are deducted, and markups and margins by intermediaries are added.**

- **Total manufacturer net sales in 2019 were $356 billion and increased at a 4.6% CAGR over the past five years. Manufacturer net sales is calculated after deducting negotiated rebates, discounts, coupons, vouchers, and other price concessions.**

- **Manufacturer net sales have increased by $56 billion over the past five years. $68 billion of growth from new branded medicines, and $40 billion of growth from increased use of existing brands. Offset by $70 billion reduction in sales from loss of patent protection.**

source: IQVIA Institute August 2020: Medicine Spending and Affordability in the United States

CMS Drug Utilization Data - Michigan



ACCESS – Network Adequacy

Appendix 14 Medicaid Health Plan Provider Network Standards					
	non-rural		Rural		ALL
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Ratios Provider : Enrollee
Primary Care Providers (adult)	30 minutes	30 miles	40 minutes	40 miles	1:500
Primary Care Providers (pediatric)	30 minutes	30 miles	40 minutes	40 miles	1:500
OB/GYN	30 minutes	30 miles	40 minutes	40 miles	
Cardiology	30 minutes	30 miles	40 minutes	40 miles	
Outpatient Behavioral Health*	30 minutes	30 miles	75 minutes	75 miles	
Hospital	30 minutes	30 miles	60 minutes	60 miles	
Pharmacy	25 minutes	25 miles	30 minutes	30 miles	
General Dentistry	30 minutes	30 miles	40 minutes	40 miles	Kalkaska [1:692] Missaukee [1: 873] Schoolcraft [1:806] All other counties [1:650
To be counted in the PCP or general dentistry ratio calculation, a provider must be enrolled in Medicaid, and must be at least full-time (minimum of 20 hours per week per practice location)					

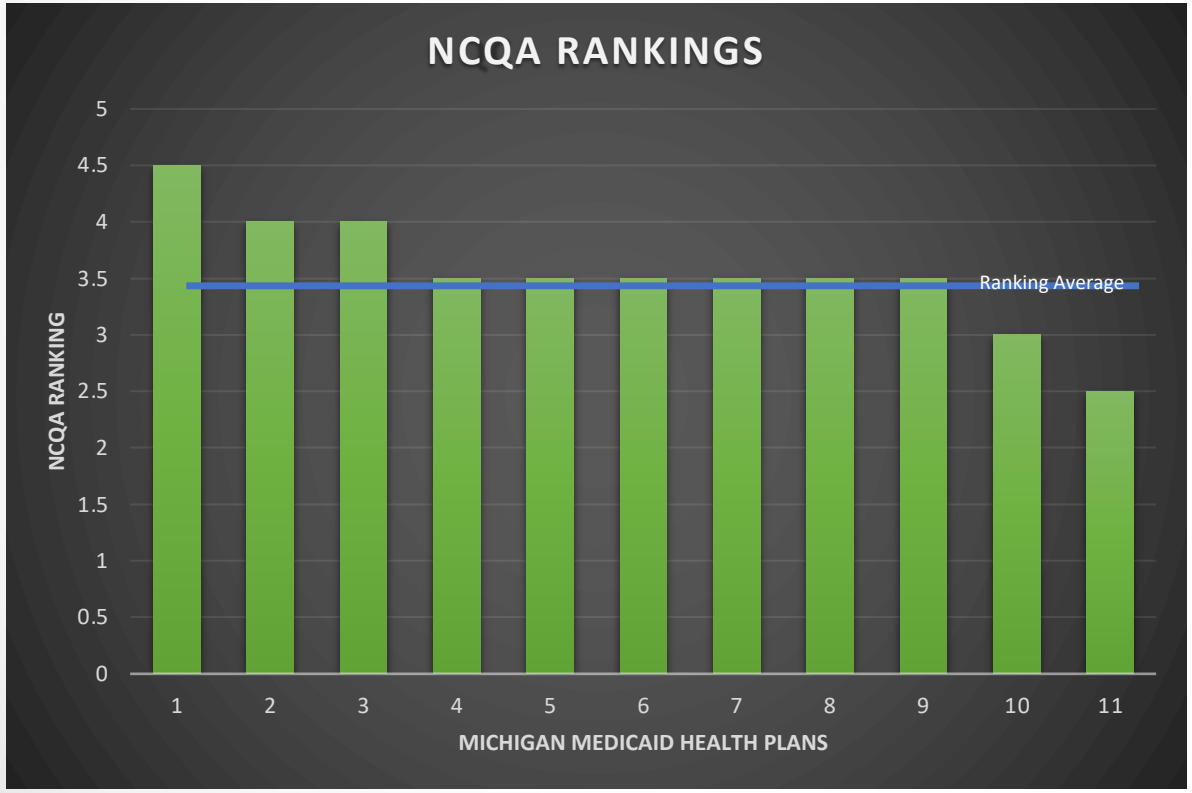
Payment to Providers

- Timely Payments Contractor must make timely payments to all Providers for Covered Services rendered to Enrollees as required by 42 CFR §447.45 and MCL 400.111i and in compliance with established MDHHS performance standards

Date of Receipt	% of Clean Claims Paid
Within 30 Days	90%
Within 90 Days	99%

QUALITY – Performance Measurements

- **Medicaid services under managed care are accountable**
  - Audited data related to clinical quality of care measures (HEDIS)
  - Use of external measures to determine customer satisfaction (CAHPS)
  - Contract performance standards (Status improvement, access measures, etc)
  - Reporting requirements as licensed HMOs and Contracted Medicaid Plans



–National Accreditation and rating through NCQA/URAC, who compare the quality and services of more than 1,000 health plans that collectively cover 138 million people—more than 43% of the nation's population through stressing health outcomes and consumer satisfaction

Conclusion

- Michigan's Medicaid Program
  - Is a national leader in many areas while emphasizing sound fundamentals
  - Is setting a new trend with Healthy Michigan; incentivizing health behaviors and personal responsibility
  - Is cost effective while delivering access and quality services to beneficiaries
  - Tracks performance through a wide range of metrics
  - Will continue to pursue cutting edge policies that improve program performance

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MAHP Resources

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