FY 2019-20

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 13 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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Our members

Aetna Better Health of Michigan [1,2,3]

Michigan Complete Health [3]

Harbor Health Plan [2,3]

Health Alliance Plan [1,2,3]

Molina Healthcare of Michigan [1,2,3]

Physicians Health Plan [1]

Total Health Care Plan [1,2,3]

McLaren Health Plan [1,2,3]

Meridian Health Plan [1,2,3]

Paramount Care of Michigan [1,3]

Priority Health [1,2,3]

Upper Peninsula Health Plan [2,3]

United Healthcare Community Plan [1,2,3]

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

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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.

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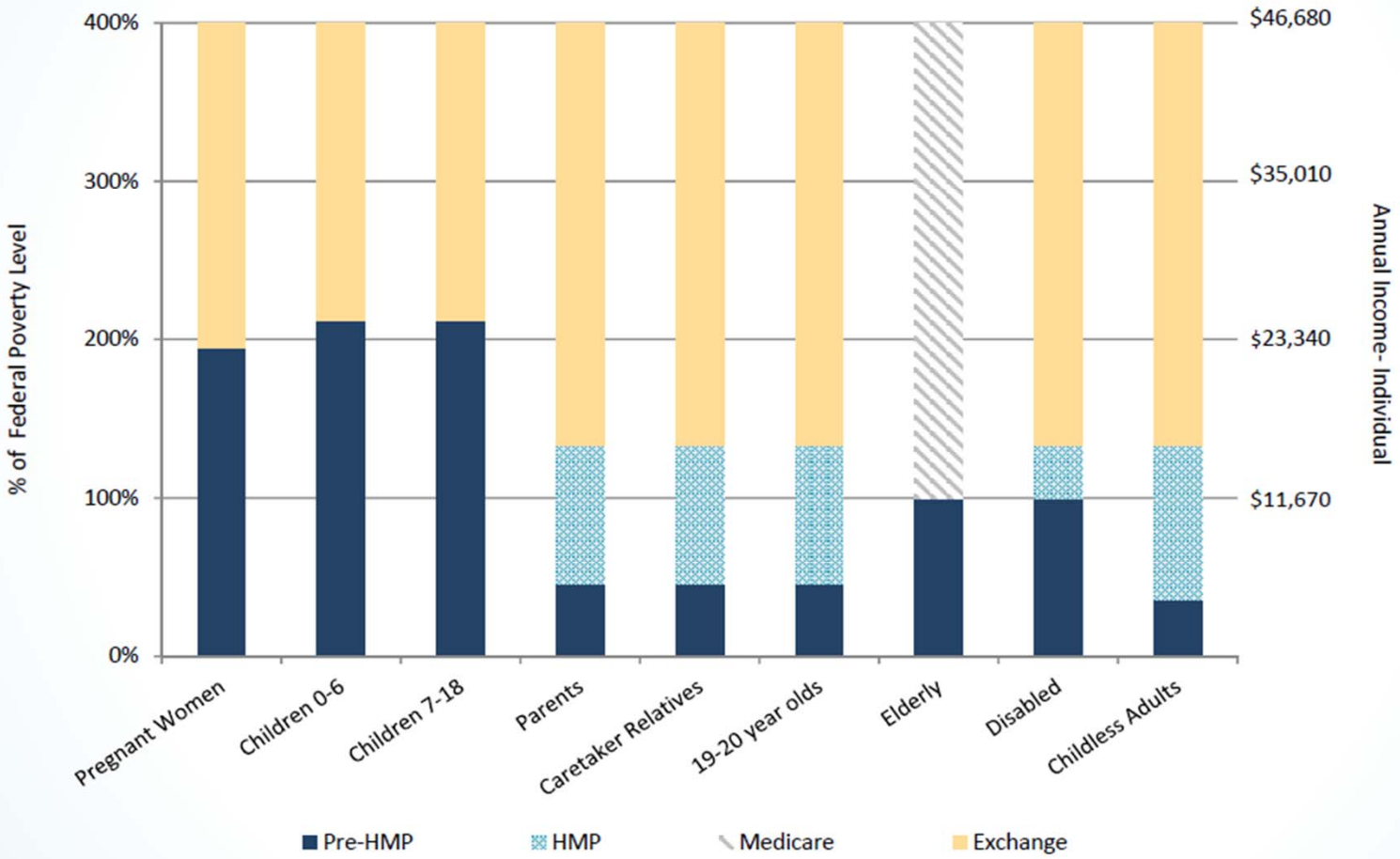
Eligible Populations



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

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Managed Care

•**Medicaid services are managed and costs are predictable—savings** over $400 million/year (compared to FFS)—Nearly $5 billion in savings to Taxpayers since 2000.

•**Managed care provides greater access to care**

Robust Health Plan provider networks

No wait list for Medically necessary and clinically appropriate services

•**Smart Incentives built into Medicaid Contracts with private health plans**

Provides the structure that generates state savings

Return on Investment (improved health status, access and costs savings)

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Managed Care Enrollment

Source: DHHS Green Book and Monthly Enrollment Reports

CY	Month	Medicaid Eligible (including HMP)	Medicaid Eligible (Excluding HMP)	Health Plan Enrollee (Medicaid and HMP)	Health Plan Enrollee (Excluding HMP)	HMP	Health Plan HMP Enrollee	MI Health Link Enrollee
19	Feb			1,766,762	1,231,369		535,393	34,446
19	Jan '19			1,753,126	1,226,604		526,522	34,370
18	Dec			1,752,955	1,218,387		534,568	34,659
18	Nov	2,458,624	1,775,564	1,757,413	1,217,194	683,060	540,219	34,828
18	Oct	2,471,197	1,785,666	1,779,885	1,236,180	685,531	543,705	35,662
18	Sep	2,476,906	1,790,739	1,790,274	1,239,363	686,167	550,911	36,396
18	Aug	2,476,291	1,790,781	1,774,676	1,230,358	685,510	544,318	37,105
18	Jul	2,484,436	1,795,545	1,784,541	1,230,165	688,891	554,376	37,805
18	Jun	2,481,435	1,791,029	1,782,303	1,230,790	690,406	551,513	38,328
18	May	2,487,980	1,792,064	1,781,385	1,231,412	695,916	549,973	39,021
18	Apr	2,493,997	1,794,099	1,721,231	1,198,234	699,898	522,997	37,831
18	Mar	2,499,464	1,798,761	1,713,717	1,192,057	700,703	521,660	38,576
18	Feb	2,496,430	1,797,697	1,752,011	1,221,307	698,733	530,704	38,623
18	Jan '18	2,499,870	1,802,552	1,784,339	1,242,644	697,318	541,695	37,958
17	Dec	2,491,139	1,799,885	1,778,889	1,241,926	691,254	536,963	38,509
17	Nov	2,487,938	1,803,344	1,776,455	1,239,889	684,594	536,566	38,580
17	Oct	2,478,477	1,801,208	1,783,087	1,243,908	677,269	539,179	38,430

MI Health Link

- Demonstration program for Dual Eligible (Medicaid/Medicare) adults ages 21 and over in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne, and any county in the Upper Peninsula.

- Offers medical and behavioral health services, pharmacy, home and community-based services, and nursing home care – all in a single program.

- MDHHS annually assesses the perceptions and experiences of members in the program as part of their evaluation using the Health Services Advisory Group, Inc (HSAG) to administer a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. These findings are compared to nine national NCQA averages for the Medicaid program (Rating of Plan, Customer Service, Getting Care Quickly, Getting Need Care, etc…).

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MI Health Link

- For 2018 the MI Health Link Program scored at or above the 90th percentile on four measures (including customer service). Scored at or between the 75th and 89th percentile on three measures. Scored at or between the 50th and 75th percentile on one measure.

- Mandated annual "Managed Care Savings" for both Medicaid and Medicare. 3% mandatory savings proposed for 2018 rates.

- Rates for CY 2018 and CY 2019 not yet approved. Demo scheduled to conclude December 31, 2020.

- System issues causing major loss of enrollment. Down 12% since last February. Passive enrollment turned off since early 2018.

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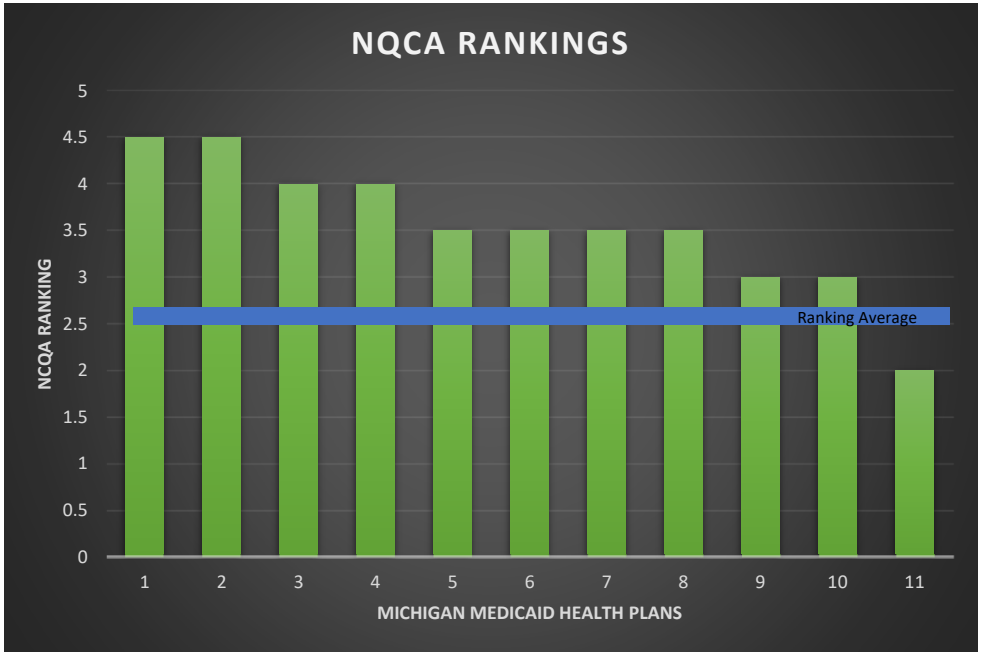
Medicaid Managed Care

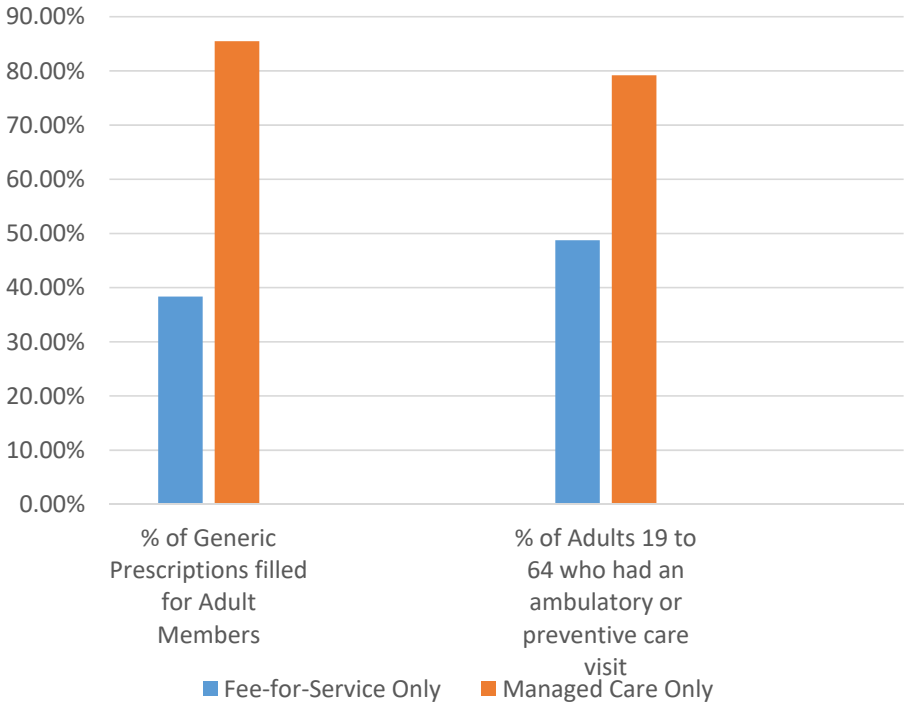
- Medicaid services under managed care are accountable
  - Audited data related to clinical quality of care measures (HEDIS)
  - Use of external measures to determine customer satisfaction (CAHPS)
  - Contract performance standards (Status improvement, access measures, etc)
  - Reporting requirements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

Medicaid Managed Care

Performance Monitoring



The Comprehensive Health Program Contract consists of 26 standards aimed at monitoring health plan performance in important areas of quality, access, customer service and reporting. The standards address the following:

- MDHHS Administrative Measures
- Healthy Michigan Plan Measures
- Healthy Michigan Plan Dental Measures
- CMS Core Set Measures/Health Equity HEDIS/HEDIS/Managed Care Quality Measures

Medicaid FFS RX Expenditures		
Fiscal Year	**Appropriated Expenditures**	**Change year to year**
2014	$263.7 million	
2015	$268.0 million	1.7%
2016	$319.4 million	19.2%
2017	$305.1 million	-4.5%
2018	$296.4 million	-2.9%
2019	$332.2 million	12.1%

Prescription Drug Trends for Michigan Medicaid Managed Care Organizations			
Eligibility Category	**FY17/16**	**FY18/ FY17**	**Average FY18/FY16**
TANF	-1.7%	5.1%	1.7%
ABAD	5.4%	9.1%	7.2%
CSHCS	6.6%	3.3%	4.9%
HMP	10.9%	4.9%	7.9%

Prescription Drug Spending Growth Slower but Continues to Rise

- **U.S. prescription drugs spending rose to $453 billion in 2107; a 6% growth compared to previous increases of 12.5% over previous 2 years**
- **Spending growth slower than previous years, however prices for brand prescriptions continues to rise, increasing by 58% over the past 5 years**
- **Spending continues to shift from traditional drugs to specialty drugs which now account for 46.5% of drug expenditures**
- **Biologic specialty drugs comprise 11.5 billion in spending**

IQVIA Institute April 2018: Medicine Use & Spending in the U.S. – A review of 2017 and Outlook to 2020

Top 10 Drugs Reported on data.Medicaid.gov

32% of Drug Spend

Volume Rank	Drug Name	Indication for Use	$ Volume (Millions)	2017 Volume Rank	Cost Trend
1	HUMIRA	Rheumatoid Arthritis	$23.2	13	4.0%
2	BASAGLAR	Diabetes	$22.6	19	-0.1%
3	SYMBICORT	Asthma/COPD	$22.6	2	5.7%
4	VENTOLIN	Asthma/COPD	$15.7	3	2.3%
5	NOVOLOG	Diabetes	$11.2	7	1.6%
6	QVAR	Asthma/COPD	$8.5	4	7.8%
7	CHANTIX	Smoking Cessation	$8.4	9	12.0%
8	ENBREL	Rheumatoid Arthritis	$8.2	12	8.2%
9	HUMALOG	Diabetes	$8.1	8	4.3%
10	INCRUSE	Asthma/COPD	$7.1	38	-1.1%
Total			**$135.5**		**3.2%**

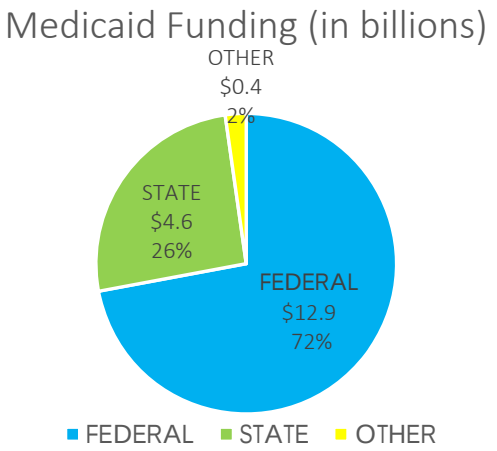
Historical Pharmacy Trend

TANF	Util/1000	Cost per Script	Claim Cost PMPM
FY 2016	0.57	$371.47	$17.65
FY 2017	0.55	$380.89	$17.31
FY 2018	0.55	$395.37	$18.24
FY 2018/FY2017	1.5%	3.8%	5.4%
Average FY 2018/FY 2016	-1.5%	3.2%	1.7%
Milliman FY 2018 Rate Development			6.5%
Milliman FY 2019 Rate Development			7.1%

HMP	Util/1000	Cost per Script	Claim Cost PMPM
FY 2016	1.56	$438.12	$56.93
FY 2017	1.56	$481.92	$62.82
FY 2018	1.53	$519.07	$66.22
FY 2018/FY2017	-2.1%	7.7%	5.4%
Average FY 2018/FY 2016	-0.9%	8.8%	7.9%
Milliman FY 2018 Rate Development			8.0%
Milliman FY 2019 Rate Development			6.1%

BLOCK GRANT FUNDING

- Current Medicaid Funding (FY 16-17)
  - Currently, states share the cost of Medicaid with the federal government
  - 12.9 Billion Dollars from the Federal Government (estimated)
  - 4.6 Billion Dollars from the State (estimated)



A block grant or per capita cap would be a fundamental change to Medicaid financing.

	Current Medicaid Program	Block Grant	Per Capita Cap
Coverage	• Guaranteed coverage, no waiting list or caps	• No guarantee (can use wait lists or caps)	• May be guaranteed for certain groups
Federal Funding	• Guaranteed, no cap • Responds to program needs (enrollment and health care costs) • Can fluctuate	• Capped • Not based on enrollment, costs or program needs • Fixed with pre-set growth	• Capped per enrollee • Not based on health care costs and needs • Fixed with pre-set growth per enrollee
State Matching Payments	• Required to draw down federal dollars • Federal spending tied to state spending	• Unclear • Federal spending not tied to state spending beyond cap	• Unclear • Federal spending not tied to state spending beyond per enrollee cap
Core Federal Standards	• Set in law with state flexibility to expand	• Uncertain what the requirements would be to obtain federal funds	

Source: Kaiser Family Foundation

Budget and Policy Considerations

- **Actuarial Sound Rates:**
  - Federal regulations require capitated rates to Health Plans to be certified by an actuary and cover all federal, state, and local taxes, fees, and assessments.
  - Encounter Quality Initiative (EQI) data evaluated from all 11 Medicaid Health Plans. Review of eligibility category historical pricing and experience trend, historical pharmacy experience and trend, and office administered drug experience trend.
  - Review suggests a needed actuarial soundness rate increase between 2.4% and 4.9% for FY 20.
  - Average FY 19 rate increase across all populations was 2.8%
  - For comparison: Average federal and state Medicaid spending grew by 4.2% in FY 18, and state project average growth of 5.3% in FY 19.

- **FMAP Changes:**
  - Reduction of 0.39% (From 64.06% down to 64.45%) requires corresponding increase in state funds to maintain status quo.
  - Healthy Michigan Plan reduction of 3% with Calendar Year 2020 (From 93% down to 90%)

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Budget and Policy Considerations

- **Adult Dental Carve-in:**
  - Healthy Kids Dental, Healthy Michigan Plan, and Pregnant Women already have benefit managed through a full-risk bearing managed care entity. Remaining FFS adult dental population should be integrated for improved utilization of preventive services.

- **Managed Long Term Supports and Services:**
  - MCL 400.105d Subsection (4) instructs the Department to plan to enroll all existing FFS populations into Health Plans if cost effective. Department currently "exploring" options as required in previous year boilerplate.

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Behavioral Health Integration

The current system using partial-risk Prepaid Inpatient Health Plans (PIHPs) to manage a siloed behavioral health benefit for the Medicaid population is failing. 8 of 9 PIHPs reported spending more on Medicaid services than the state had budgeted for them for FY 18 (Medicaid/HMP expenditures were greater than Medicaid/HMP revenue). Three 'one-time" bail outs have occurred in supplementals in the last two years and there is a need for more.

Managed Care is the predominant financing model for state Medicaid programs, with nearly 40 states contracting with Managed Care Organizations (MCOs) to provide all or some physical health benefits for beneficiaries.

States are seeking better ways to coordinate physical and behavioral health services with the goal of improving outcomes and reducing unnecessary utilization. A reasonable timetable should be planned for statewide behavioral health integration with the designated "298 pilot" areas moving first.

Network Adequacy standards and a state fee schedule should be developed and enforced. A risk corridor to prohibit profiteering should be created. Health Plans should be required to contract with all Community Mental Health Service Providers within their area of service. Health Plans should be allowed to contract with behavioral health service providers outside of the CMHSPs network in order to enhance access to care.

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Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

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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