2024 Pinnacle Awards

mahp Foundation

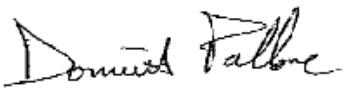
Welcome

On behalf of the Michigan Association of Health Plans and the Michigan Association of Health Plans Foundation, welcome to the Pinnacle Awards Presentation.

Since 2001, The MAHP Pinnacle Awards for Best Practices has recognized health plans for achievements in addressing the challenges of a shifting health care environment through improvements in operations, clinical services, disease management and community outreach. As our members face the challenges associated with an uncertain and changing landscape, they continue to innovate, improve and inspire. The Pinnacle Award continues to serve as an emblem of excellence to the member plans that are recognized with it.

This year, eight of our member plans submitted 21 innovative programs demonstrating creative approaches to solving problems and improving services in the commercial, Medicare and Medicaid sectors. This year, our panel of 10 judges, representing other healthcare organizations, government and businesses, deliberated and chose our Pinnacle Award winners. Our judges are very thorough in their review of the submissions and they always learn a great deal about managed care in Michigan through this process. Their thoughtful attention is greatly appreciated.

Thank you for joining MAHP and the MAHP Foundation to celebrate the achievements of Michigan health plans and to recognize the dedicated individuals who are committed to improving the health of their members and their communities.



Dominick Pallone
Executive Director, MAHP

Lisa Farnum
Managing Director, MAHP Foundation

Table of Contents

2024 Pinnacle Award Judges

The Michigan Association of Health Plans Foundation and the Michigan Association of Health Plans

extend their profound thanks to the judges for the generous contribution of their time and expertise.

Representative Brenda Carter
State Representative
District 53

Representative Bradley Slagh
State Representative
District 85

Senator Michael Webber
State Senator
District 9

Alethia Kasben
Managing Editor
Gongwer

Norm Hess
Executive Director
Michigan Association for Local Public Health

Megan Blue
Senior Director of Healthcare Payor Policy
Michigan Health and Hospital Association

Phillip Bergquist
Chief Operating Officer
Michigan Primary Care Association

David Worthams
Director of Employment Policy
Michigan Manufacturers Association

Kathy Stiffler
Health Policy Consultant
MSU Institute of Health Policy

Michelle Beebe
Chief Revenue Officer
Small Business Association of Michigan

Mom and Baby Beginnings

HAP CARESOURCE

According to Michigan's Maternal Mortality Surveillance Program, approximately 90 maternal deaths occur each year, of which two-thirds are preventable. In 2021, HAP CareSource began "Mom and Baby Beginnings" to provide innovative care supporting maternal and infant health.

The program, designed to improve maternal and infant health outcomes by reducing preterm births, cesarean rates, increasing infant birth weight, and reducing Emergency Department and hospital utilization, engages members through risk assessments to identify medical, behavioral and social needs, ensuring an appropriate level of care. More than 77 percent of engaged members were screened for postpartum depression, identifying 17 percent with a behavioral health risk who received referrals and resources.

The program continues through the fourth trimester postpartum and offers new mothers support for breastfeeding, depression, parental counseling, and returning to the workforce. As of late 2023, 1,082 members enrolled in the program, with HAP CareSource identifying high-risk factors early in pregnancy and solutioning to improve outcomes.

Sickle Cell Warriors: Guarding the Future by Improving Pediatric Sickle Cell Care

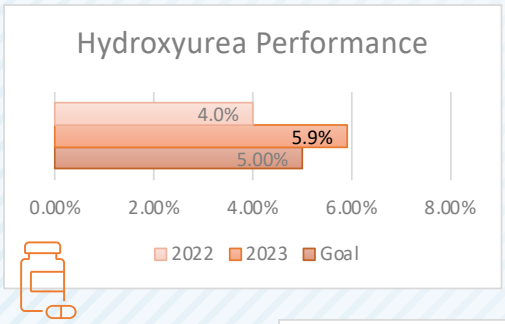
MERIDIAN

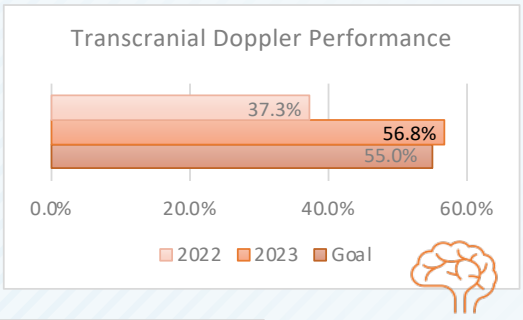
To promote health equity Meridian, in partnership with Michigan Department of Health and Human Services (MDHHS) and Michigan Medicine, recognized the need for a more individualized approach when advocating and providing care management services to members with Sickle Cell Anemia. The Sickle Cell Program was designed using a multidisciplinary care team which aimed to decrease disease-specific gaps in care as well as addressing SDoH barriers. With the interventions from Meridian's care team:

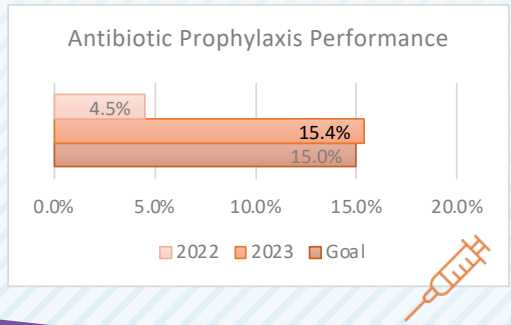
With the interventions from Meridian's care team:

- Member hematologist visit rates increased 0.66% overall and by 2.69% within the Region 10 population.
- Transcranial Doppler rates increased 9.26% overall and by 19.46% within the Region 10 population.
- Antibiotic prophylaxis rates increased by 13.11% overall and by 10.83% within the Region 10 population.
- Hydroxyurea rates increased by 0.16% overall and by 1.88% within the Region 10 population.

Meridian surpassed MDHHS provided metrics and effectively engaged with members by becoming partners and advocates in their plan of care.



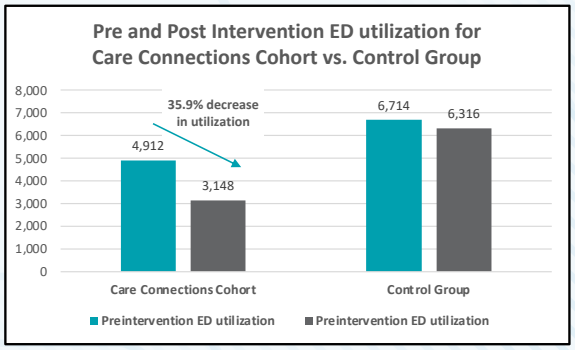




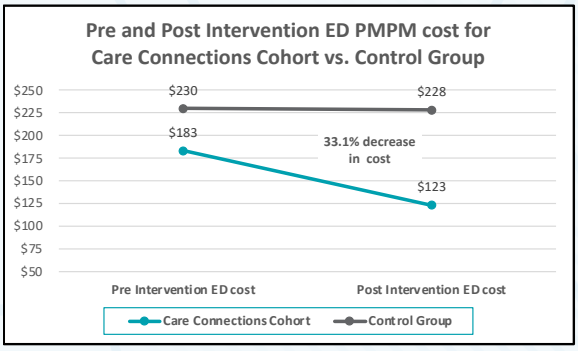
Improving Care and Coordination After an ED Visit for Members with Substance Use Disorder

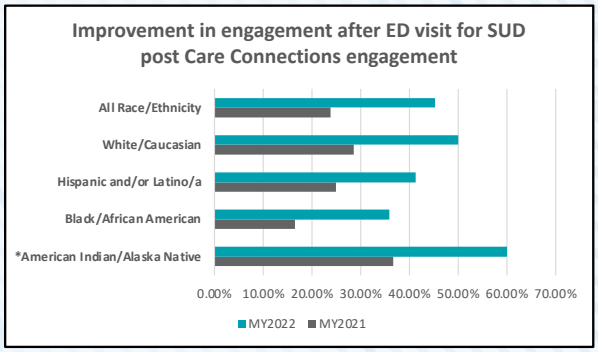
MOLINA HEALTHCARE

In 2022, Molina began a new program to identify members discharged from the Emergency Department (ED) for Substance Use Disorder (SUD) so they could be referred for outreach and completion of a follow-up visit with a Molina Care Connections Psychiatric Nurse Practitioner. This initiative was designed to improve care, coordination, and equity for members with SUD as measured by the HEDIS measure Follow-up After Emergency Department Visit for Substance Use (FUA).



The FUA rates of all measured racial/ethnic groups and the overall rate improved from MY2021 to MY2022.





Measurable Clinical Outcomes

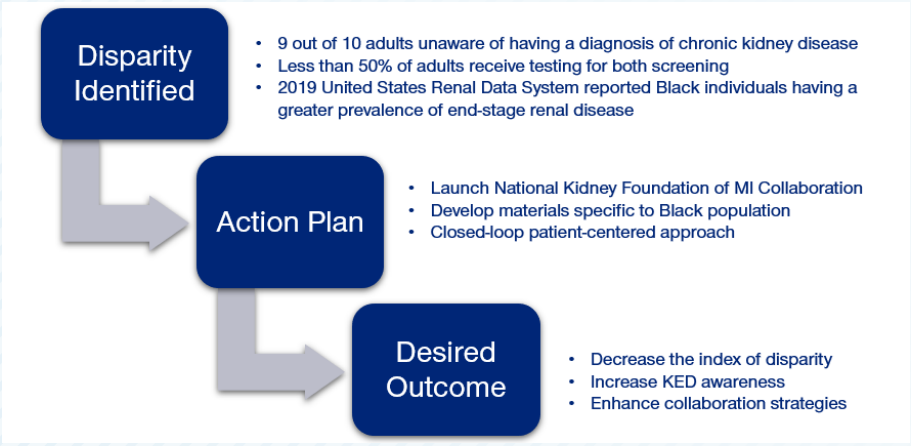
UnitedHealthcare Community Plan

Improving Kidney Health

UNITEDHEALTHCARE COMMUNITY PLAN OF MICHIGAN

UnitedHealthcare Community Plan (UHCCP) partnered with the National Kidney Foundation of Michigan (NKFM) to improve Kidney Health Evaluation for Patients with Diabetes (KED), a key risk factor for developing kidney disease. By sharing their claims analysis with NKFM, UHCCP played a pivotal role in prompting updates to KED screening best practices for providers.

To advance health equity, UHCCP worked with NKFM to develop evidence-based KED educational material specific to the Black population who experiences a higher prevalence of chronic kidney disease. Integration of these materials into NKFM's comprehensive 'Are You the 33%' toolkit made it accessible to all Michiganders.



The Upper Peninsula Maternal Opioid Misuse (UP MOM) Initiative

UPPER PENINSULA HEALTH PLAN

Addressing the pressing issue of maternal opioid misuse in Region One, the Upper Peninsula Maternal Opioid Misuse (UP MOM) Initiative, led by UP Health Plan (UPHP) and UP Health Care Solutions, implements a groundbreaking care coordination model. Over three years, UP MOM leverages community health workers (CHWs) to provide comprehensive support, from behavioral health treatment coordination to Medication Assisted Treatment (MAT) services. Remarkable outcomes include high rates of prenatal and postnatal care compliance, reduced inappropriate emergency department visits, and increased engagement with providers for MAT. Notably, the initiative significantly decreases neonatal abstinence syndrome (NAS) severity and NICU admissions.

As UPHP assumes fiscal responsibility, UP MOM transitions into a permanent care coordination initiative, with plans for expansion into additional counties. This innovative model not only addresses the complexities of opioid use disorder during pregnancy but also serves as a beacon of hope for improved maternal and infant health outcomes in the region.

Our Services

Tailored Care Coordination

-Enhancing an enrollee's ability to effectively communicate with healthcare providers.
-Advocating for service, community, and health resources.
-Providing coordination and follow up of referrals.

Supportive Services

UP MOM coordinates with Maternal Infant Health Program (MIHP), service agencies, and community based organizations as well as health care providers housed in birthing hospitals, addiction treatment, behavioral health, and OB/GYN offices to reduce barriers to care and increase engagement.

Stability

UP MOM CHWs assist enrollees with securing basic needs to stabilize the family and focus on treatment. They work in concert with home visiting programs and seek to provide immediate response to needs as they arise.

A **community health worker** is a frontline public health worker who has a unique understanding of the pregnant and postpartum individual experiencing opioid use disorder (OUD). This trusting relationship enables the worker to serve as a liaison between health and social services and the individual to improve the health outcomes of mom and infant.
Any health care professional may request the assistance of a CHW to coordinate:

- Ongoing medical or social services appointments
- Completing forms for Transportation, housing, clothing, or food assistance
- Family education & support
- Referral coordination upon discharge - medical, MAT, behavioral health, and/or OBGYN

Referring to UP MOM

UP MOM can provide same day assistance upon request by any health care provider or service agency.

Who Qualifies?

- Women who are Pregnant and up to 12 months Post Partum.
- and those who have experienced any level of Opioid Use Disorder or treatment.

Please begin by completing the Universal Referral Form at: www.uphcs.org/upmom or email kkeough@uphcs.org.

In Marquette County, you may also call us directly at:

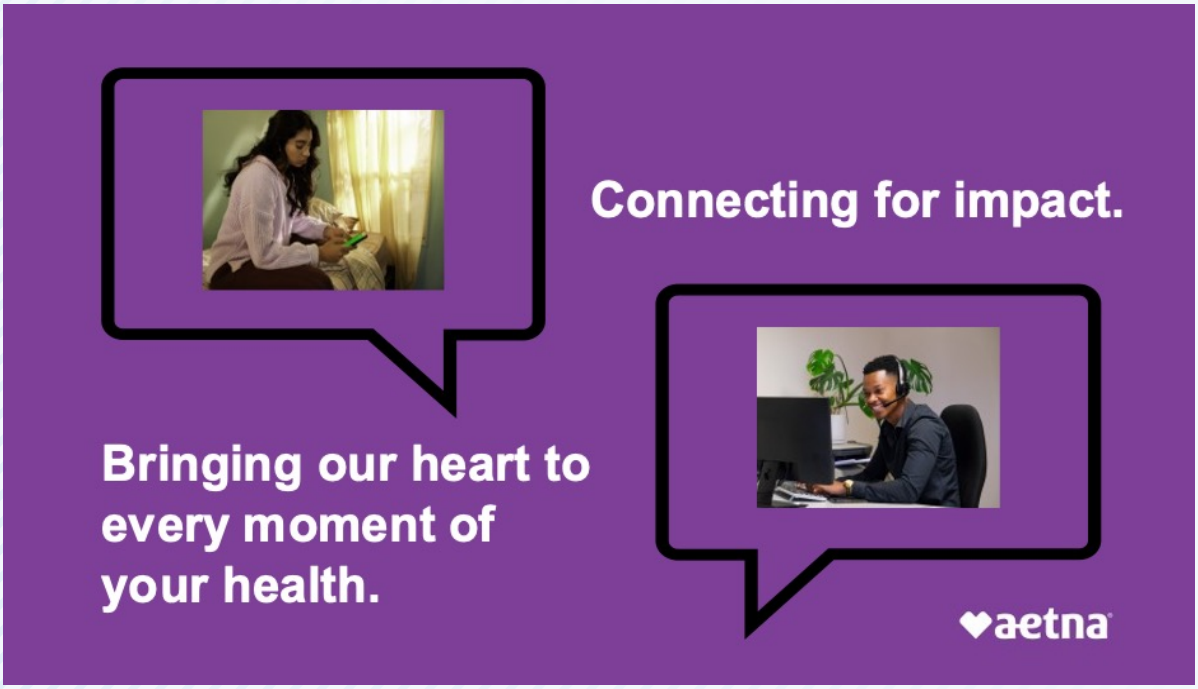
- 906-227-5698 | UP MOM
- 906-315-2631 | MIHP

The Power of Connection

AETNA BETTER HEALTH OF MICHIGAN

Aetna Better Health of Michigan works to adapt and change program offerings to meet their members' needs, strengthening their clinical and operating efficiencies and enhancing their effectiveness in the process. In recent years, they noticed their members were experiencing a new set of health issues, reporting higher instances of loneliness, social isolation, anxiety, and depression. They knew they had to act to ensure their members' whole-person care needs were being addressed. Aetna started exploring ways to partner with organizations to address social isolation and loneliness and found Pyx Health to be the perfect partner.

The collaboration between Pyx Health and Aetna has allowed Care Managers and Population Health staff to be innovative in addressing social determinants of health. This is another tool in the Care Management toolbox to meet the needs of our members. Since inception, their members using the platform have reported remarkable results!

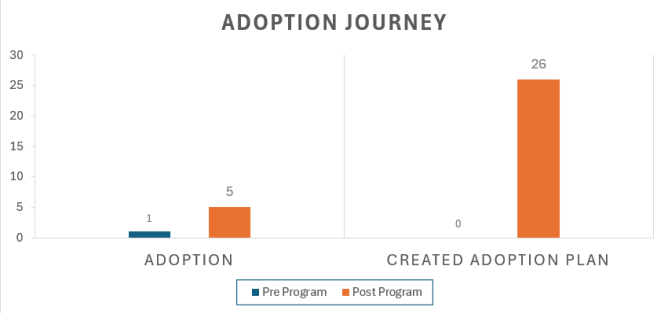


Improving Member Experience through Innovative Partnerships/Delivery Models - Fertility and Family Building

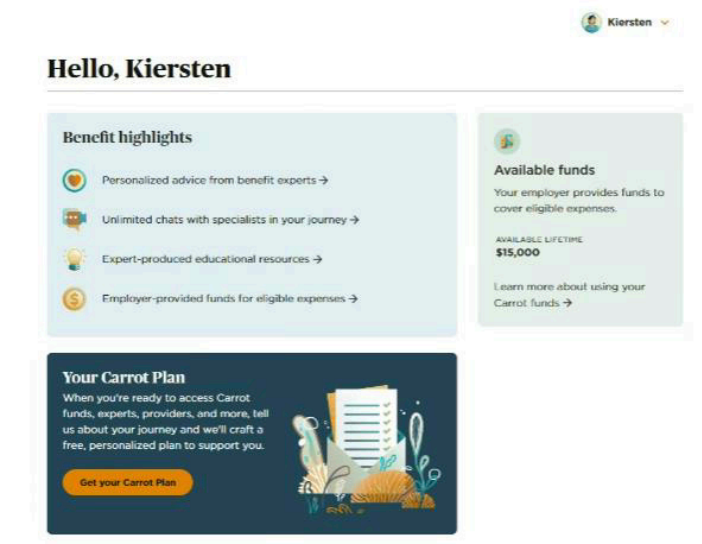
HEALTH ALLIANCE PLAN (HAP)

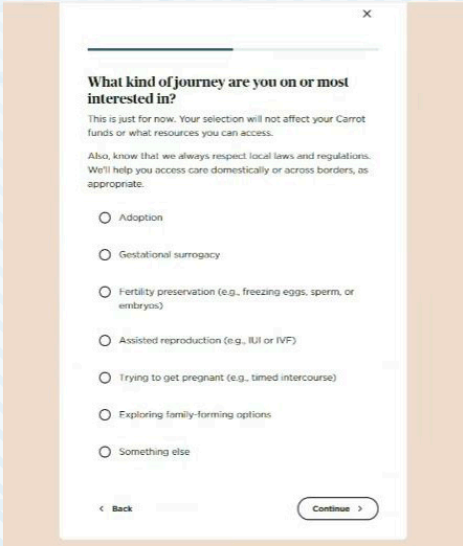
In collaboration with Henry Ford Health and Carrot Fertility, HAP launched a comprehensive fertility and family-building program in April 2023 to address the substantial need for accessible fertility health care. This initiative provides crucial support to employees through services like egg freezing, IVF, gestational surrogacy, and adoption, regardless of the individual's race, sex, sexual orientation, gender, or marital status. The program features a unique, easy-to-use online platform for personalized care and expert consultations, along with an innovative payment card to eliminate financial barriers.

Notably, the program achieved impressive first-year results, with over 900 members registered and many engaged in personalized care plans with significant increases in access to adoption and fertility treatment.



This program exceeded expectations in promoting health equity and challenged the status quo with fertility care available without requiring an infertility diagnosis. The positive feedback highlights the program's effectiveness and potential for expansion to encompass more comprehensive health care needs.





Provider Quality Concierge Model: Strengthening and Streamlining Provider Support

MERIDIAN

Provider Quality Concierge Team Structure and Support System

Dedicated Concierge Team
- Manager, Provider Quality Concierge Team
- Quality Practice Advisors
- Community Health Workers

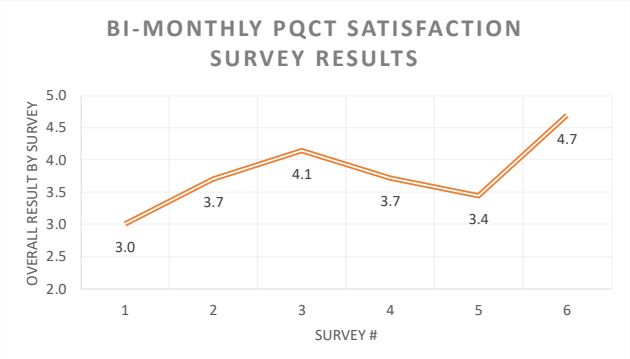
Multiple levels of leadership support for escalation
- Provider Engagement Leadership
- Provider Relations/Contracting Leadership
- Quality Improvement Leadership
- Plan President
- Chief Executive Officer

Other Senior Leadership Support
- Chief Medical Officer
- Chief Financial Officer
- Senior VP, Operations
- Senior Director, Population Health & Clinical Operations

Additional Support Staff
- Project Manager
- Business Analyst
- Contract Coordinator

In 2023, Meridian implemented the Provider Quality Concierge Team (PQCT) to improve efficiency, provider satisfaction, and patient outcomes at federally qualified health centers (FQHCs). The team creates a powerful dynamic, improving access to care by addressing barriers and providing tailored assistance for community resources, patient services, billing, claims, contracting, and more. This is achieved by partnering Provider Engagement (PE), Quality Improvement (QI), Community Health Workers (CHW), pharmacy, analytics, and project management. Utilizing a multidisciplinary team exemplifies Meridian's goal to ensure our provider partners see our dedication to serving them and our members.

Not only has the PQCT increased overall provider satisfaction from 60% to 94% since the team's inception but they have also participated in 27 events and donated 2,000+ items to FQHCs (including 21 lead analyzers and 13 retinal cameras) impacting around 50,000 Meridian members. One FQHC saw an 8.47-12.57% improvement in their Maternal-Child HEDIS® measures from 2022-2023.



Social Solitude: Harnessing Technology to Combat Loneliness

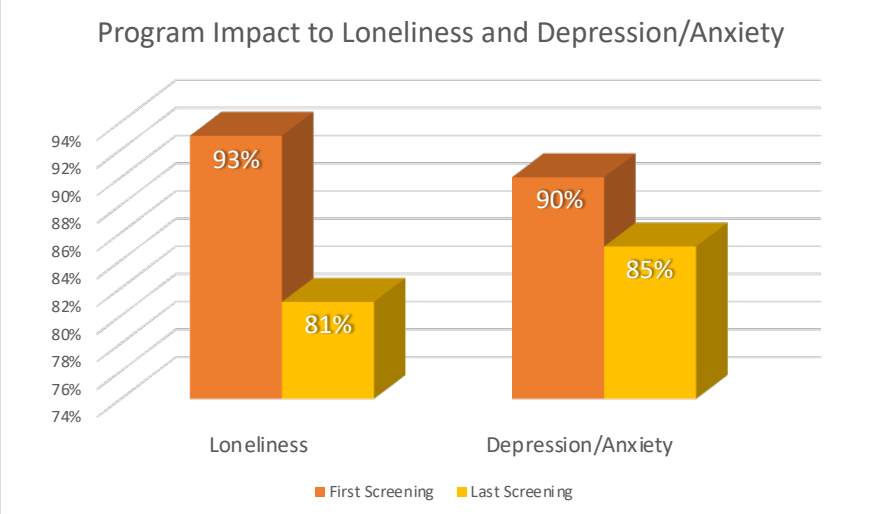
MERIDIANCOMPLETE

hronic diseases, health disparities, and diversity, equity, and inclusion are all critical concerns plaguing our society today. But what about loneliness? MeridianComplete (Meridian) has teamed up with Pyx Health (Pyx) to treat loneliness like any other chronic health condition by bringing awareness, education, and solutions to Meridian's membership.

The Pyx mobile app connects members with support staff, or ANDYs (Authentic, Nurturing, Dependable, Your Friend), who are overseen by a clinician. ANDYs will guide members through assessments, connect them with resources, and provide virtual support in real-time.

Since the inception of the partnership, Pyx has completed 9,735 activities with Meridian members spanning topics such as stress reduction, celebrating progress, memory games, mindful eating, and habit trackers. These activities are intended to help increase the meaningfulness of existing relationships and identify positive characteristics, strengths, and psychological assets.

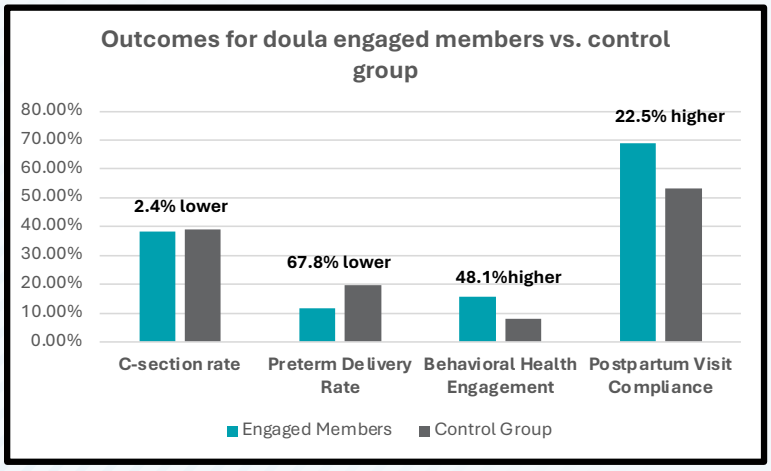
In 2023, Meridian has seen reductions program enrollee loneliness by 12% and depression/anxiety by 5%.



Improving Member Experience through Innovative Partnerships/Delivery Models: Decreasing Maternal Health Disparities through Leveraging Doulas at Molina

MOLINA HEALTHCARE

Black individuals in the U.S. are more likely to suffer adverse health outcomes or death during the perinatal period compared to non-Black populations. In 2023, MDHHS expanded Medicaid coverage to include doula services. Doulas are non-clinical, trained professionals who advocate for their pregnant patients during the perinatal period. Based on this support, doulas are effective in decreasing racial disparities in maternal health care. Molina Healthcare of Michigan leveraged this new benefit to improve maternal health outcomes for Black members. Molina engaged with Mae Health, a program that works with Black pregnant members to screen them for health risks, provide perinatal education and resources, and partner the member with a local Black doula. Based on a case control evaluation, Molina found that Black members who engaged with this program were less likely to have a C-section or preterm delivery and more likely to receive behavioral health support and complete their postpartum visit.



Primary Care Partnerships to Support Preventive Care Services

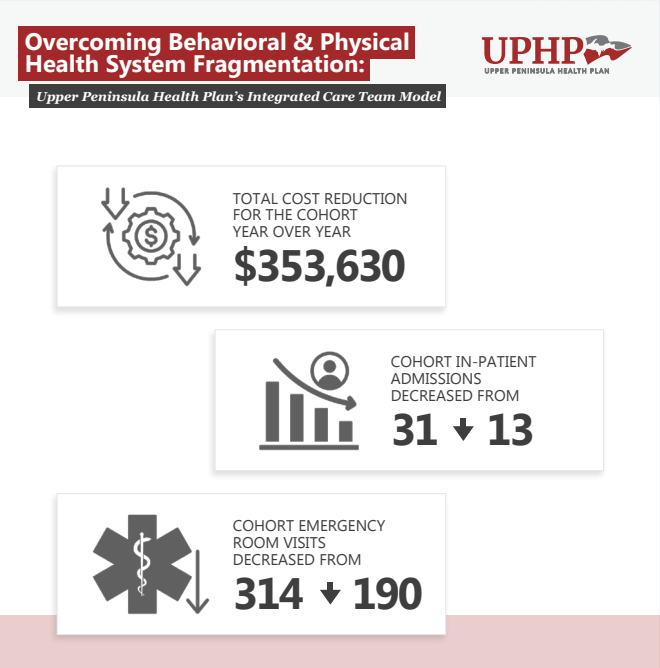
UNITEDHEALTHCARE COMMUNITY PLAN OF MICHIGAN

UnitedHealthcare Community Plan (UHCCP) improved engagement in preventative care services amongst their members by engaging primary care providers (PCPs) in a cobranding initiative. This initiative promotes collaborative member outreach by UHCCP on behalf of the provider alleviating the administrative burden on the provider and fostering increased engagement amongst members. Member outreach includes a cobranded letter identifying preventive services due and education regarding the importance of receiving those services. Cobranded letters include the PCPs direct scheduling phone number as well as information on contacting community health workers for additional assistance and transportation. Among participating PCPs, there was a 42.64 percent improvement in Adults' Access to Preventive/Ambulatory Health Services and a 34.62 percent improvement in Child and Adolescent Well-Care Visits.

Overcoming Behavioral and Physical Health System Fragmentation: Upper Peninsula Health Plan's Integrated Care Team Model

UPPER PENINSULA HEALTH PLAN

The bifurcated nature of the Medicaid physical - behavioral health model can yield data exchange barriers, which limits comprehensive care coordination potential. Upper Peninsula Health Plan (UPHP) and NorthCare Network (NCN) collaborate to overcome data exchange barriers, aiming to enhance care coordination for enrollees. Through integrated care teams (ICT) and innovative strategies like the CareConnect 360 platform, they identify at-risk members, reduce hospitalizations, and improve overall health outcomes. A cohort analysis of MI Health Link dual eligible enrollees revealed significant cost reductions and decreased hospital admissions and emergency room visits.



The interdisciplinary approach addresses health-related social needs and fosters success stories like aiding a young adult with a traumatic brain injury to reduce reliance on emergent care and secure employment. UPHP and NCN continually refine ICT criteria to encompass a broader range of members, striving to deliver comprehensive, whole-person care.

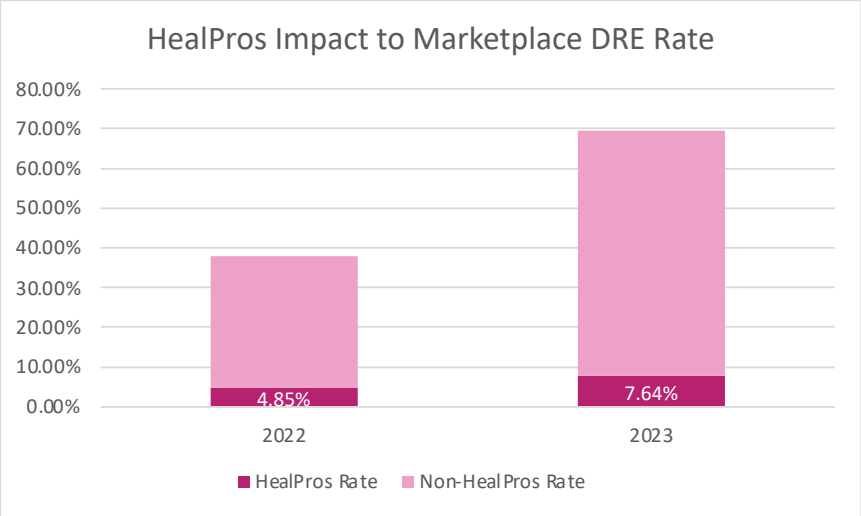
Diabetic Support at Your Doorstep: A HealPros and Meridian Partnership

AMBETTER FROM MERIDIAN

According to the Michigan Department of Health and Human Services (MDHHS), from 2019-2021 somewhere between 10-12.5% of adult Michiganders suffered from diabetes. Individuals living with diabetes have a higher chance of experiencing high blood pressure, high cholesterol, depression, cardiovascular and kidney diseases.

To meet members where they are, Meridian partnered with HealPros for an in-home program to provide diabetic preventive screenings such as retinal eye exams (DRE), kidney health evaluations (KED), along with diabetic education. Some HealPros' approaches to engaging Meridian members are sharing educational fliers, leaving door tags for individuals they may have missed, delivering, and helping members complete home-testing kits, completing screenings, and providing health coaching.

This partnership has helped Meridian reach the 90th percentile for DRE, improve KED performance by 19% since 2022, and has supported DRE and other gap closure in some of the most rural areas in Michigan.



HealPros

Community Collaborative & Member Outreach

HAP CareSource™

Fostering Humane Communities

HAP CARESOURCE

In October 2022, HAP CareSource and Michigan Humane began joining forces to provide critical health care resources, veterinary services, and important health plan information to families in need. By focusing on pets and reaching people in their own neighborhoods, they are reaching individuals who otherwise may not have sought or known about these resources.

Continuing in 2023, HAP CareSource provided direct support for the program that kept 30,000 pets with their families and out of shelters, while 2,000 families were informed of health care resources and 3,400 pets received veterinary care. Additionally, HAP CareSource's support enabled Michigan Humane to serve 7.5 million bowls of food through their Pet Food Pantry, provide nearly $3 million in pet food, and offer $619,020 in veterinary care.

HAP CareSource's contribution made a difference in the lives of pets and their families, and connected hundreds of Detroit residents to vital health care information and resources.

The REFRESH (Rural Engagement Facilitation Resources and Education for School Hygiene) Program

MCLAREN HEALTH PLAN

McLaren Health Plan is committed to improving physical and mental health in children and adolescents within their rural Michigan communities through community collaborations. The REFRESH Program is a collaboration with Central Michigan District Health Department to collect and distribute hygiene products to students in rural Michigan schools. Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon County schools are involved in this project. Donated products include deodorant, shampoo, conditioner, soap, lotion, and menstrual products.

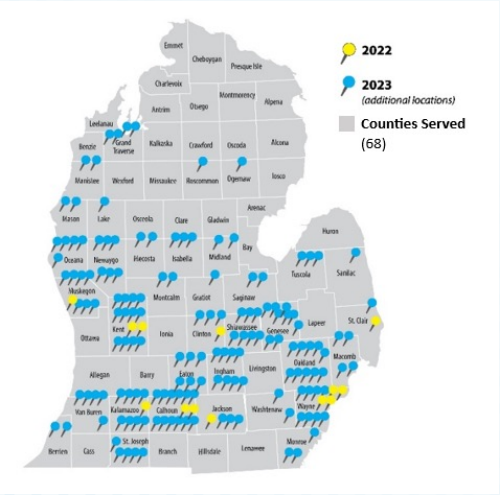
Children attending school with hygiene issues are at high-risk of bullying by peers which may cause serious health and behavioral problems including depression, academic failure, and eating disorders. These conditions may follow children throughout their lifetime. This project provides a lifeline to children who otherwise do not have basic hygiene access/resources. Early intervention interrupts these negative childhood events leading to improved health and wellness outcomes.

Community Collaborative & Member Outreach

Amplifying Community Engagement to Better Serve Michiganders

MERIDIAN

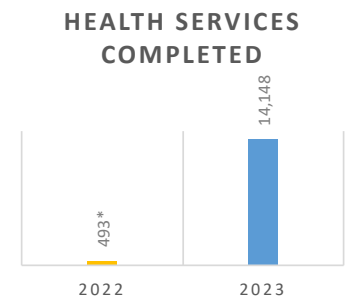
Community Event Locations 2022 vs. 2023

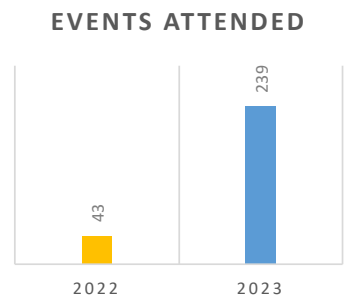


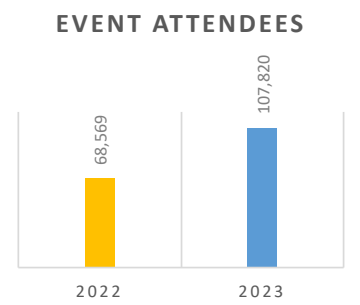
Partnering with community-based organizations and attending community events ensures Meridian builds lasting relationships with entities who are working towards improving health equity in each of our servicing regions.

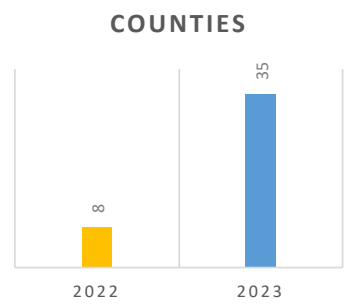
Meridian's goal is to maintain a strong community presence and work with community stakeholders to improve the health of communities and address social determinants of health that impact each region. To meet these goals, in November 2022, Meridian invested more resources into its community engagement program. This investment enabled greater capacity for Meridian to use member and community level data to identify underserved populations, build community engagement initiatives that meet the needs of those populations and improve reporting on event outcomes.

The graphs below outline the impacts from 2022 to 2023:









Community Collaborations: Working with Members, Communities, and Providers to Improve Redetermination Impact

MOLINA HEALTHCARE

When the Public Health Emergency (PHE) ended in May 2023, Michigan Medicaid members were required to renew their Medicaid coverage. Molina Healthcare of Michigan adopted a multifaceted approach to inform members and the community about the risk of members losing their Medicaid coverage.

Molina partnered with many communities to hold 56 redetermination events in 6 regions to raise awareness and help people renew their Medicaid coverage. They implemented a communication plan to reach members in multiple ways to make them aware of the need to renew coverage including member outreach via postcards, phone, texts, email, prescription refills, social media, and via our contact center. We also educated and trained both primary care providers and Community Based Organizations on Medicaid renewals.

This multi-pronged approach allowed us to renew 123,441 members and recapture 13,873 members so that these members all continue to have access to high quality health care.

Housing Chronic Disease Management Project

PRIORITY HEALTH

Safe and stable housing has a critical impact on our health and well-being. Sadly, Kent County witnessed a 27 percent increase in homelessness from 2021-22. During this period, Priority Health found unhoused patients had eight times the ED visits than housed patients.

A partnership was established between Priority Health, Corewell Health's Medical Group and Start Now Program and Community Rebuilders to create synergy between historically fragmented solutions of primary care services, health-related social needs, technology and housing. Born out of this partnership was the Housing Chronic Disease Management Project.

The pilot project concluded in December 2023 with a cohort of 30 participants with a 58 percent improved SDoH score along with:

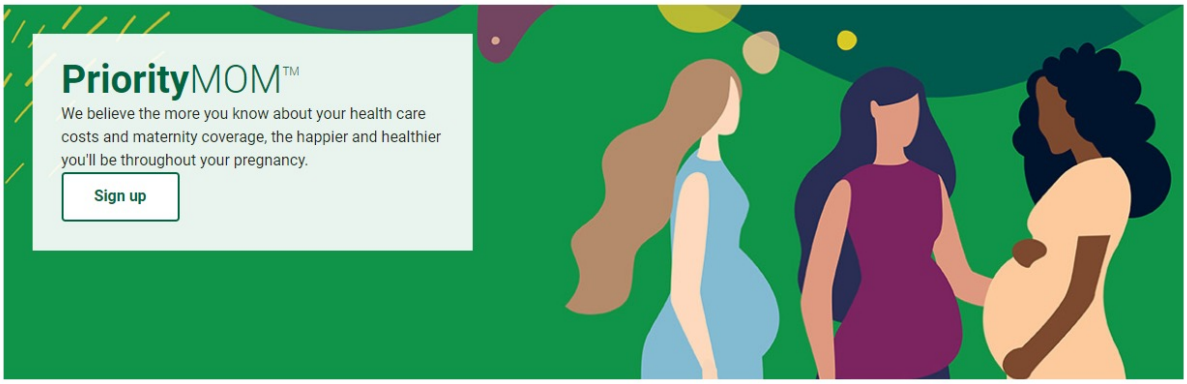
- 35 percent improved Quality-of-Life score
- 68 percent of diabetics improved blood sugar levels
- 99 percent of COPD patients achieved/maintained green zone
- 100 percent of heart failure patients achieved/maintained green zone
- 97 percent retained permanent housing post-6-months project

TESTIMONIAL #1:

An unhoused refugee with type-2 diabetes faced numerous challenges managing blood-sugar levels due to limited access to refrigerated storage for medication, lost glucometer, and inadequate diet at the shelter, exacerbated by a second-shift job and shelter policies preventing daytime rest. He stayed at the shelter for 2 years waiting for stable housing. The housing chronic disease program provided housing, health services, and resource education, leading to the participant effectively managing their health, stabilizing sugar levels, and reducing emergency department visits. The patient also exhibited an A1C reduction from 10.9% to 7% at discharge, followed by another A1C decrease to 5.4% in February of 2024. He has maintained housing and full-time employment during this time.

PriorityMOM

PRIORITY HEALTH



When priorities shift to parenthood, we've got you covered.

From the minute you find out you're pregnant to the moment you meet your baby, it seems like there are a million things to know. **Priority**MOM™ is here to help with useful—and important—information about your health, your health plan and your coverage throughout every step of the way.

PriorityMOM – Maternity Offerings for Moms - is a data-driven maternity management program designed to come alongside expectant mothers through their pregnancy with the goal of reducing preterm births and postpartum readmissions, improving health outcomes for mom and baby, reducing total cost of maternity care, and helping navigate health care and coverage.

Participants are given reminders and education designed to promote behavioral change and nudge prevention and clinically appropriate care. Content is personalized for mom based on her due date, medical history and pregnancy-related risks. Additional resources are given that cover common pregnancy issues such as hypertension, mental health and diabetes. Participants receive a welcome gift of a blood pressure cuff, a baby sleep sack and breast pump. Priority Health also offers a $50 gift card to mothers upon completion of the program. PriorityMOM gives our members an affordable, accessible, and innovative maternity program geared to meet their needs throughout their pregnancy.

UnitedHealthcare Community Plan

Targeting Health Disparities Through the Health Equity Challenge

UNITEDHEALTHCARE COMMUNITY PLAN OF MICHIGAN

UnitedHealthcare Community Plan of Michigan (UHCCP) partnered with Wayne State University to launch a Health Equity Challenge.

The goal of the Health Equity Challenge is to uncover new and innovative approaches that support health equity — reducing disparities while improving physical and behavioral health outcomes. From reducing childhood lead exposures to increasing access to healthy foods — community based organizations are encouraged to bring forward ideas that aim to address disparities based on race, language, culture, gender and/or sexual orientation.

The Health Equity Challenge highlights the commitment of UnitedHealthcare Community Plan of Michigan to improve health outcomes for individuals across the state. Through this challenge, the two organizations provide resources so that innovative solutions can be conceptualized and implemented in the community. The Health Equity Challenge serves as a catalyst for driving meaningful change and fostering a healthier, more equitable future for Michiganders and their communities.

Team members from UHCCP with team members from Lori's Hands – one of the 2024 Health Equity Challenge Winners.

Pictured (L to R): Director of Population Health at UnitedHealthcare Community Plan of Michigan Emily Williams; Lori's Hands Executive Director Zach Barton; Lori's Hands Metro Detroit Chapter Manager Maddi Riemenschneider; Associate Professor of Occupational Therapy at Wayne State University Preethy Samuel; Senior Community Outreach Specialist at UnitedHealthcare Community Plan Michigan Joy Greer

Community Collaborative & Member Outreach

Redetermination with Determination

UPPER PENINSULA HEALTH PLAN

Recognizing the potential for enrollees to lose coverage due to procedural issues, UPHP launched an extensive outreach campaign. This included forming a dedicated task force, collaborating with community organizations, and leveraging multiple communication channels such as phone calls, texts, emails, and social media. Furthermore, UPHP facilitated updates to member information with MDHHS and provided toolkits to streamline the redetermination process for providers.

As a result, 40 percent of at-risk enrollees maintained their eligibility without a coverage gap, ensuring continued access to vital medical services like cancer treatment and substance abuse care. Looking forward, UPHP remains committed to ongoing redetermination efforts to support all eligible members in maintaining their Medicaid coverage.


mahp
Michigan Association
of Health Plans


aetna
Aetna Better Health® of Michigan


cca
health
MICHIGAN


hap


McLaren
HEALTH PLAN


meridian


MOLINA®
HEALTHCARE


PARAMOUNT
Affiliate of ProMedica


Physicians
Health Plan


Priority Health


UnitedHealthcare®
Community Plan


UPHP
UPPER PENINSULA HEALTH PLAN

The Michigan Association of Health Plans applauds your dedication to providing innovative, outstanding service and quality for your members. Your commitment to achieving the highest standards in all you do for those you serve continues to make Michigan a leader in the health care industry.

The Michigan Association of Health Plans Foundation collaborates with public and private partners to conduct research projects related to managed care, chronic disease and health care quality improvement; and to provide education and resources for the public and for health professionals about chronic disease. This foundation is a 501(c)3 nonprofit organization.

The MAHP Foundation also works with a variety of health, social welfare, and education groups in collaboration with state agencies to expand efforts toward a statewide awareness of Adverse Childhood Experiences (ACE). Visit the Michigan ACE Initiative website for more information at miace.org.

Dominick Pallone
President, MAHP Foundation Board of Directors

Lisa Farnum
Managing Director, MAHP Foundation

mahp Foundation

327 Seymour, Lansing, Michigan 48933 | Phone: (517) 371-3181