Michigan Association of Health Plans
SUMMER 2016

insights

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Michigan Association of Health Plans

MORE INSIDE

Mid-Year Assessment: We're Making Progress

By Rick Murdock, Executive Director, Michigan Association of Health Plans

We have just finished the legislative session before summer recess and the results of several key legislative decisions were in play: the budget for FY 17, Senate passage of "repurposing" use tax on Medicaid health plans, and the final adoption of the Insurance Code package.

Individually, each of these items were important to MAHP members, but taken together, they represented a strong endorsement for future viability for our members in various product lines and it is a testament to the advocacy efforts of MAHP members and our team that such actions are taken. Let me describe why — and thank the Legislature for the actions they have taken.

1. FY 17 Budget and Impact for MAHP Members

We view the development and implementation of the state budget each year as one of the milestones for our industry. As Medicaid has grown into managed care in Michigan, the overall Medicaid health plan line has now become one of the largest line items in the state budget.

That is the good news as it reflects the confidence gained over time of the legislative and various administrations. It is also bad news as it becomes a target for any reduction and any year-to-year change necessary will dwarf other budget items.

Our strategic plan development and annual Medicaid white paper hone in on the key budget and boilerplate provisions that we see as critical to the ongoing management and efficiency of our members and overall viability. We were pleased again to see that once again, the fiscal recommendations are largely supportive. The tenets of "actuarial soundness" assure that appropriate fiscal changes are considered in both the budget and rate development phases. **This principle was met in this budget as a 1.5 percent increase for traditional Medicaid and a 2 percent increase for healthy Michigan were adopted.**

continued on page 3

Protect Your Investments

By Bill Burke, Knight Consulting

We are all familiar with the concept of investing for the future. We attempt to do it in our personal lives through pensions or Individual Retirement Accounts. No matter the method, the concept is sound. If done properly, it allows us the peace of mind that the future holds promise for our families. The same concept holds true regarding the most current topics of improving our roads and bridges, adequately funding our schools and providing a sound infrastructure for clean water throughout the state. These represent only the tip of the iceberg.

Each item within the appropriations process represents an investment by taxpayers that must result in a benefit to the citizens of this state. The legislators who appropriate and those who must later vote in agreement to the budgets must be convinced that the funds are being allocated correctly to meet the needs of those who fund services through their tax dollars. Constituents demand accountability in the appropriations (investment) process. They expect and demand accountability by elected officials to supply governmental services in the most cost effective manner.

Citizens have a right to demand the same accountability as it relates to governmentally funded health care. The Michigan Legislature has appropriated $10.5 billion dollars to ensure that over 2.4 million citizens receive health care benefits. The state and its partners in health care provide both physical and behavioral health benefits to Medicaid, Mi Child and Healthy Michigan Plan recipients. The Michigan Association of Health Plans fully supports and appreciates the investment the Legislature and state agencies have provided in this endeavor. It is through this partnership in which this investment is protected.

The appropriations process is cumbersome and thorough. Each line item is reviewed, analyzed and deliberated until a consensus is attained. The hours of research and preparation by legislators and budget staff is remarkable. Unlike their federal counterparts, Michigan legislators are bound by the state Constitution to provide a balanced budged each year. Simply stated, they can't spend more than they have generated in tax dollars. As a result, budgets are highly influenced by revenues generated by the voting public. At this point, good policy becomes wed to the political realities of each district.

Due to the ever present shortfall between good ideas and available funds, legislators must make the final call on where to place available funds to invest.

The Michigan Legislature has appropriated $10.5 billion dollars to ensure that over 2.4 million citizens receive health care benefits.

This is also the time for them to protect the investments they have made. Within the healthcare arena, they protect their investment through language in the budget bills, known as boilerplate language. The requirements put forth in boilerplate direct the departments and their partners/vendors to fulfill the expectations of the legislature once the funds are appropriated.

While many of the requirements of health plans are contained within the individual contracts signed with the state, many others are included in boilerplate to give the legislature assurances that their investment is sound. The importance of the language relates to the fact that it can either enhance or inhibit organizations from meeting their objectives. The importance of actuarial soundness of the provisions contained in health plan contracts cannot be overstated.

This is the reason why your association fully participates and engages in boilerplate discussions related to the budget process. MAHP extends its appreciation to all members who assist in this process and will continue to provide answers and solutions as problems arise during negotiations.

Bill Burke has been an associate of Knight Consulting since 1998. Prior to that, he was Director of Legislation and Associate Executive Director of the Michigan Dental Association. His duties included lobbying healthcare issues at the state and federal levels for the 14 years that he held those positions. He has been a registered lobbyist for 20 years, specializing in health care, insurance and appropriations issues.

Mid-Year Assessment *(continued from page 1)*

Related to the fiscal changes, are instructions for how overall funding should be allocated — or budget boilerplate. Among the key MAHP recommendations on boilerplate adopted in the budget were the following items:

- Health Plans to assist in eligibility redetermination — this will help avoid breaks in enrollment
- Use of NCQA/URAC accreditation — or deeming — as way to save on both health plan expense and that of the Michigan Department of Health and Human Services in its oversight
- Performance standards and capitation withhold to use HEDIS data, continuous enrollment criteria, and notification of standards at least three months before implementation
- Reporting on cost of Michigan Health Information Network participation by health plans due to the requirement of the contract between plans and the network.
- Creation of a new demonstration project for incentives between consumers and providers that capitalizes on medical literacy
- Provisions governing the "Common Formulary" that provides means for health plans management techniques that are evidence based and emphasizes e-prescribing

The issue receiving the most attention in the budget this year was the focus on "integration" — that is, how best to serve the overall health needs of the "whole person."

Historically, Michigan has administered a split benefit in Medicaid that too often results in poor coordination and lost opportunities for total health care. As a follow-up to the Medicaid rebid of last year and consistent with the policy changes occurring across the country, Governor Rick Snyder recommended a move toward integrating the Medicaid benefit within the Medicaid Health Plan contract as part of the FY 17 budget recommendation. While there is ample justification for such a recommendation, the impact on the legacy system of CMHSPs and PIHPs was large. The recommendation raised confusion and fear among consumers regarding accessing services through an abrupt change.

As we well know now, a large stakeholder group was assemble to work through key concepts and principles for integration and improvement in the overall delivery of services and the final FY 17 budget has taken those recommendations into account. **While still advocating movement toward integration, the final budget anticipates the following:**

- Continuation of a stakeholder group, including Medicaid Health Plans to help shape a report/plan to be submitted to the legislature that will guide the movement toward integration;
- Production and submission of final report by January 15, 2017;
- Inclusion within the report of benchmarks to measure progress toward implementation of integration over a three period;
- Consideration of the use of one or more pilot programs; and
- Detail on outcomes, including core values adopted by the Stakeholder group, person centered planning, community based services, and savings to be redirected for services.

Fundamentally, the decision and urgency on integration continues to rely on MDHHS leadership. Moreover, the impact on the implementation of the new Medicaid "Mega Rule" and Medicaid parity rules cannot be understated and will undoubtedly require contract and policy changes that will positively impact movement toward integration. MAHP has communicated our support for the overall budget and the direction of the language on integration, and looks forward to working with the various stakeholders, providers, and representatives of the MDHHS to bring this vision to fruition.

2. Repurposing of the Medicaid Health Plan "use tax." Senate Bills (987, 988, 989, 990).

Michigan has historically relied on various special taxes to support the general fund and therefore Medicaid services. A prime example of this is the current imposition of Michigan's sales and use tax (6 percent) on Medicaid services provided by Medicaid Health Plans and Prepaid Inpatient Health Plans, PIHPs. While many believe this is an appropriate state taxing vehicle, CMS has raised concerns about the use of this tax (used by Michigan and other states) to arrive at revenue for federal match. Agreement by the Executive Office and fiscal agencies to not use this revenue beyond December 31 has created an issue for Medicaid Health Plans that must be addressed through either repeal of the use tax on health plans or repurposing the use of revenue from the tax to satisfy CMS. While repealing the use tax may ultimately be necessary to protect the financial viability of health plans, MAHP believes the best policy is to first seek an acceptable approach to "repurpose" the use tax provision that will meet the requirements of CMS.

At the same time, many in the business environment continue to believe that the Health Insurance Claims Assessment, also known as HICA, unfairly increases costs of business. They are interested in expediting an ultimate repeal of that act. As a reminder, HICA was established to replace the use tax back in 2011—and while amended several times since then, remains in force including amendments this year to extend HICA to 2020.

These two items are now the focus of the Senate Bill package (SB 987-990) that meets the MAHP supported objective of providing a sustainable means of supporting the general fund while covering the expense of the use tax and continue that tax on Medicaid Health Plans. If this can be done and repeal HICA at the same time, then it is a "win/win" proposition.

MAHP has worked closely with Senate leadership and the business community to address these objectives in concept papers and then in draft legislation that is now SB 987-990. This legislation was introduced, hearings were held in the Michigan Competitiveness Committee, and Senate passage took place on June 8th—moving

continued on page 4

Mid-Year Assessment *(continued from page 3)*

the package to the House—being referred to the House Insurance Committee. These bills do the following:

1. SB 987. Moves effective rate of HICA to 0% in 2017 and repeals the act in 2018.

2. SB 988. Establishes a new Health Services Trust Fund to receive the deposit from the Use tax. The trust fund then limits the expenditures from the trust fund to only non-Medicaid programs in the state budget.

3. SB 989. Amends the Use Tax to clarify that revenue is to be deposited in the new Trust Fund established by SB 988.

4. SB 990. Amends the State's income tax act to provide revenue to cover the actuarial soundness requirement (cost of the use tax).

We appreciate the leadership of the Legislature in moving this package and will continue to work with House members to secure final passage in order to submit a formal request to CMS for their approval of this approach yet this calendar year.

3. Reforming Michigan's Insurance Code

For more than two years now, MAHP and its members and consultants have been working through a comprehensive review and update of Michigan's Insurance code provisions that affect health insurance. This effort started internally following the enactment of the conversion of Blue Cross/Blue Shield to a mutual insurance company. Our overall objective was to keep Michigan laws strong and relevant to Michigan in context of federal law and recognize changes in the insurance marketplace both with respect to the types of health insurance plans that are sold and the types of entities offering coverage. The key recommendations include:

- Provisions to allow health insurers the ability and greater flexibility to develop new products in response to market demands.
- Modernizes the Insurance Code to embrace electronic means of communication.
- Creates a clear definition of "health insurer" which includes HMOs except when otherwise specified. Avoids confusion between the differences of "insurer" and "HMO."
- Reduces regulatory requirements by streamlining the readability scoring process conducted by DIFS in certain cases where products are similar. Deletes outdated requirements that are no longer relevant to today's market.
- Clarifies that several insurance mandates currently in law only apply to health insurance, and not to auto, life, or property and causality insurers.
- Allows HMOs to provide Administrative Services Only (ASO) products through the HMO entity in order to better respond to recent market trends as more employers look to self-insure.
- Revises the Code to conform to timeline in federal law (ERISA) for processing grievances. Simplifies compliance for consumers and insurers.
- Updates the Patient's Right to Independent Review Act to enable Michigan to maintain its own external review process, rather than defaulting to the federal one

The Legislature has now completed their work and has adopted the reform package.

MAHP will be featuring the highlights of the changes at our Summer Conference as well as developing materials to assist members in working though the various changes. The issue of competition within the insurance market is more pronounced now than ever, and we are hopeful these changes will enable MAHP members to successfully compete in the marketplace and offer affordable coverage options to individuals, small groups, large groups, and governmental payers.

Starting the planning for the new Fiscal Year, we anticipated a fiscal "cliff" in state resources that would require us to take major steps to protect the eligibility, enrollment of consumers in Medicaid. Perhaps we have only "kicked the can" forward another year, but success with the repurposing of the use tax will go a long way toward sustaining a sound and viable Medicaid program. Likewise, adopting fundamental changes in Michigan's insurance code should enable Michigan's health plans to become more competitive and to respond quickly to market forces for innovation.

As I noted in my last column, out of "crisis" comes opportunity and this is our opportunity to make a difference. Michigan taxpayers and our fellow citizens deserve nothing less.

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MAHP Insights is a quarterly publication of the Michigan Association of Health Plans. Past issues may be found at the MAHP website: www.mahp.org. For information regarding advertising or inclusion of news and events, please contact Christine Gray at the MAHP office 517.371.3181.

Cascade Genetic Screening: Improving Hereditary Cancer Risk Identification

By Michigan Department of Community Health Genomics Division

There are certainly challenges to identifying individuals at risk for hereditary cancer. However, once a mutation has been identified in an individual, determining which of his/her relatives are at increased risk should be relatively straightforward. Cascade genetic screening is the process of identifying the at-risk relatives of individuals with hereditary conditions, like hereditary breast and ovarian cancer syndrome (HBOC) and Lynch syndrome (LS), and has been identified as an important component of public health practice1.

Cascade genetic screening is the process of identifying the at-risk relatives of individuals with hereditary conditions like hereditary breast and ovarian cancer syndrome (HBOC) and Lynch syndrome (LS) and has been identified as an important component of public health practice.

Recognizing when there is a familial mutation present means that relatives then typically need only be tested for that specific mutation (targeted mutation analysis). Targeted analysis is much less expensive than the sequencing-based strategies used to identify a mutation in the first person tested in the family and is extremely informative.

About 1 in 300 to 1 in 500 people in the general population have a mutation in the BRCA1 or BRCA2 genes that cause HBOC; the rate is 1 in 40 in those of Ashkenazi Jewish descent2. Similarly, the same statistics shows true for the general population having a mutation in the mismatch repair (MMR) genes that cause LS. In contrast, the risk of having a BRCA or MMR gene mutation is 50 percent for each sibling or child of a BRCA or MMR mutation carrier and 25 percent for second degree relatives (nieces, nephews, aunts, uncles).

HBOC and LS are autosomal dominant conditions. Women with BRCA mutations are at high risk of developing early onset breast cancer and ovarian cancer. Men are at increased risk for breast cancer and prostate cancer, with higher risks in those with BRCA2 mutations. Men and Women with MMR mutations are at high risk of developing colon cancer and stomach cancer as well as other cancers. In addition, women are at increased risk for endometrial and ovarian cancer. Increased surveillance and prophylactic measures can potentially prevent cancers and save lives4. **Cascade genetic screening provides an opportunity to identify those at highest risk of carrying a mutation and reduce HBOC- and LS-related morbidity and mortality in these individuals.**

To increase the rate of cascade genetic screening and improve hereditary cancer risk identification, the help of both providers and health plans needs to be enlisted.

Providers are being encouraged to:

- **ASK** whether any of their patient's relatives have had genetic testing for hereditary cancer and the outcomes of such tests
- **TELL** their patients who have a mutation in a hereditary cancer gene to inform their relatives
- **RECOGNIZE** that when there is a familial mutation, relatives need only be tested for that specific mutation (targeted mutation analysis)
- **ENCOURAGE** their patients to update heir family history information regularly through conversations with their relatives so that they can keep abreast new information such as genetic test results
- **CONSIDER** working with genetic counselors who have expertise in facilitating conversations between relatives

Health plans are being encouraged to:

- **DEVELOP** a policy that covers genetic counseling and testing for both male and female members when a known mutation is present in the family

Promoting cascade genetic screening is one way to improve the identification of those at risk for hereditary cancer and reduce hereditary cancer-related morbidity and mortality. Improved identification requires increasing awareness through public health efforts aimed at patients, providers, health systems, health plans, and other stakeholders.

Should you have any questions or would like further information about cascade screening, please contact Nancie Petrucelli at (313) 576-8704 or petrucel@karmanos.org

References:

[1]*Cascade genetic screening and public health practice: an idea whose time has come. Genetic Alliance and University of Michigan Center for Public Health and Community Genomics. Accessed June 2014. Available at https://www.youtube.com/watch?v=lhcpTR7zlN0*

[2]*Petrucelli N, Daly MB, Feldman GL. BRCA1 and BRCA2 Hereditary Breast and Ovarian Cancer. GeneReviews™ [Internet]. Seattle (WA): University of Washington, Seattle; 1998 Sep 4 [Updated 2013 Sep 26]; Accessed Jun 2014, Available from: http://www.ncbi.nlm.nih.gov/books/NBK1247/*

[3]*American Society of Clinical Oncology (ASCO) Working Group (2003). ASCO policy statement update: Genetic testing for cancer susceptibility to cancer. Journal of Clinical Oncology 21(12), 2397-2406.*

[4]*Riley B.D, Culver J.O., Skrzynia C., Senter L.A., Peters J.A….Trepanier A.M. (2012). Essential elements of genetic cancer risk assessment, counseling, and testing: Updated recommendations of the National Society of Genetic Counselors. Journal of Genetic Counseling 21, 151-161.*

Moving the Competitive Needle

By: Dusty Fancher, Midwest Strategy Group

Health care is expensive. In an era where coverage is mandated and benefits are highly regulated, there is a significant focus on the cost of health insurance policies. We know competition in the market can help to slow the premium cost curve. When evaluating the impact of legislation lawmakers should consider how the potential changes would move the needle in relation to competition.

Michigan's health insurance market is less competitive than in neighboring states. The Henry J. Kaiser Family Foundation released a report in the fall of 2015, "Analysis of Insurer Participation in 2016 Marketplace." Indiana, Illinois and Ohio all had more insurers in the market place, on a per county basis, than Michigan. In addition, these states also saw competition either remain stable or grow between 2015 and 2016, where Michigan saw a net decline in the number of plans in the same time frame. Furthermore, seven counties in Michigan only had one or two options to choose from.

State policy has a direct impact on the competition in the market – both on the number of plans and the overall price of premium. Laws on tax policy, mandates, and transparency all play a role in setting the overall price of a premium.

Recently, the Michigan legislature passed bipartisan legislation championed by Representatives Tom Leonard, Tom Barrett and Bob Kosowski that will allow insurers to better meet the needs of their customers. Modernizing the Insurance Code will reduce administrative burdens for companies and provide them with increased flexibility in plan design. The hope is to attract more plans and drive down the cost of insurance.

The Senate also passed legislation that repeals the Health Insurance Claims Assessment (HICA), while providing long-term stable Medicaid funding. This policy is another example of a significant step forward in continuing to make Michigan an attractive market for insurers to grow their business, while helping reduce a driver of premium increases.

Both the HICA repeal and modernizing the Insurance Code are examples of policy's supported by commercial insurers, business groups, and Medicaid providers. Their success hinged on various interest groups setting aside their personal affairs and deciding to act for the overall good. These policies are moving the needle in a positive way.

Legislation aimed at promoting one procedure, one drug, or one interest group usually reduces the competition and drives up the overall cost. Policies that mandate coverage, revise billing procedures and regulate pharmacy needs to be carefully examined in relation to cost and competition.

Mandates, often well intentioned, add to the cost of health care. Supporters of each of these cause often note how little their particular insurance requirement would increase the overall cost of the plan. However when one adds all the various mandates together the cost becomes significant, for the consumer and the state. With the enactment of ACA, states are required to pay for mandates above the established essential health benefits. And for businesses looking to establish or grow in Michigan, mandates simply increase the cost of providing employee health insurance.

Proposals aimed at pharmacy regulation warrant particular caution. Prescription drugs are a major driving force in the cost of insurance. The projected drug spend in the United States is expected to grow from $337 billion in 2015 to between $569 billion and $590 billion by 2020. And as utilization and drug prices continue to rise, The Centers for Medicare & Medicaid Services (CMS) projects sustained increases in drug spending of 6 percent or more annually from 2015 to 2022.

These increases are, in part, due to the rise in specialty drugs. In fact, specialty drug approvals by the FDA exceeded traditional drug approvals every year since 2010. In 2014, 53 percent of the drugs approved by the FDA were specialty drugs. These specialty drugs represent 1 percent of the prescriptions, but account for more than 32 percent of the overall pharmacy spending. And according to AHIP, a leading insurance trade group, 47.8 percent of specialty drugs cost more than $100,000 per patient.

With insurance policies benefits restricted by federal laws on actuarial soundness, increases in the cost of pharmacy benefits must be balanced with a reduction of benefits in other areas. This is especially problematic when anti-competitive strategies are used to restrict access to less costly, high-value generics and therapeutic alternatives. In order to move the needle in the right direction, lawmakers should consider proposals aimed at increasing transparency and support health plans who have developed innovative strategies to contain cost associated with pharmacy and specialty drugs. In addition, policy makers need to carefully consider the consequences of laws that would create barriers or restrict the use of biosimilars.

Insurance costs, in part, are driven by the risk a market is required to bear. As Michigan lawmakers continue to focus on making the insurance market more competitive, more innovative, and more transparent, the best policies will continue to be a result of collaboration.

Dusty Fancher is a partner with Midwest Strategy Group. Over the last 20 years she has served as the governors deputy director of legislative affairs, a legislative liaison for the Michigan Department of Transportation and worked as a policy analyst for the Michigan Senate. Dusty specializes in issues relative to transportation, education, and insurance.

2016 MICHIGAN ASSOCIATION OF HEALTH PLANS

Summer Conference

July 20-23, 2016

Working Agenda-at-a-Glance

GRAND TRAVERSE RESORT, ACME, MI

All general sessions will be held in Governor's AB, Lower Level.

WEDNESDAY, JULY 20

Noon

Conference Registration Desk opens
Governors Pre-function, Lower Level

MDHHS Luncheon and Bi-monthly Meeting

3:00-5:00 p.m.

Pre-conference Program: Common Formulary and Specialty Drugs Update
MODERATOR: ***Karen Jonas, RPh,*** *MAHP Pharmacy Consultant*

5:00-7:00 p.m.

MAHP Medical, Pharmacy and QI Directors Meeting (By invitation only)
With Robert Anda, MD, *Co-Founder and Co-Prinicpal Investigator, ACE Study*

MAHP Board of Directors Meeting

7:00-9:00 p.m.

Opening Reception and Silent Auction with Sponsors in Exhibit Hall
Governors CDEF, Lower Level

THURSDAY, JULY 21

6:30 a.m.

Personal Wellness Option: Dental Dash
Meet in the hotel lobby.

7:30 a.m.

Conference Registration Desk opens
Governors Pre-function, Lower Level

Continental Breakfast and Silent Auction with Sponsors in Exhibit Hall
Governors CDEF, Lower Level

8:30 a.m.

Welcome and Introduction

Keynote Address: The Adverse Childhood Experiences (ACE) Study
Robert Anda, MD, *Co-Founder and Co-Principal Investigator, ACE Study*

9:30 a.m.

Prize Drawing and Stretch Break

9:45 a.m.

A Conversation with the Directors
MODERATOR: ***Mary L. Kramer,*** *Publisher, Crain's Detroit Business*

PANELISTS (invited): ***Nick Lyon,*** *Director, Michigan Department of Health & Human Services and* ***Patrick McPharlin,*** *Director, Michigan Department of Insurance and Financial Services*

10:15 a.m.

Legislative Panel: Key Budget and Policy Issues Facing Michigan
MODERATOR:: ***Mary L. Kramer***

11:45 a.m.

Adjourn (Light lunch for non-golfers in Governors Pre-function Area.)

Noon

Shotgun Golf Tournament: Wolverine Course
(Boxed lunches for golfers; meet at Golf Center)

5:30-7:30 p.m.

Reception and Silent Auction with Sponsors in Exhibit Hall
Governors CDEF, Lower Level

Dinner on your own

FRIDAY, JULY 22

7:30 a.m.

Conference Registration Desk opens
Governors Pre-function, Lower Level

Continental Breakfast and Silent Auction with Sponsors in Exhibit Hall
Governors CDEF, Lower Level

8:25 a.m.

Welcome and Introduction

8:30 a.m.

Opening Keynote: Disrupting Healthcare: When Devices Replace Medicine
Thomas Frey, *Senior Futurist, The DaVinci Institute*

Prize Drawing

10:00 a.m.

Break in Exhibit Hall with Sponsors and Closing of the Silent Auction
Governors CDEF, Lower Level

10:30 a.m.

Two concurrent sessions on changes taking place in the Michigan Insurance Code and health policy

Noon

MAHP Annual Awards Luncheon and Announcement of Silent Auction Winners

MAHP President's Report and Strategic Vision

1:30 p.m.

General Session: Innovations in Health Care

3:00 p.m.

Stretch Break

3:15 p.m.

General Session: Late Breaking News and release of MAHP Commissioned Poll

Prize Drawing

4:45 p.m.

Adjourn
Several optional evening events will be available.

Dinner on your own

SATURDAY, JULY 23

8:30 a.m.

Continental Breakfast
Governors Pre-function, Lower Level

9:00 a.m.

Welcome and Introductions and General Session: Models and Experiences of Health Plan Integration between Behavioral and Physical Health
(Two segments: National perspective and Michigan focus)

11:30 a.m.

Evaluations and Final Prize Drawing

UPHP's Dennis Smith Re-elected Treasurer for Medicaid Health Plans of America

Dennis Smith, President and CEO of Upper Peninsula Health Plan (UPHP), was re-elected treasurer of Medicaid Health Plans of America's (MHPA) board. MHPA is the leading national trade association solely focused on representing the universe of Medicaid health plans. MHPA works on behalf of 123 commercial and non-profit plans that serve over 20 million lives in 33 states and D.C. MHPA provides advocacy and research that support policy solutions to enhance the delivery of quality care to disadvantaged Americans.

"It's an exciting time for Medicaid," Smith said. "At UPHP, we see firsthand the impact access to health care has on all facets of our members' lives. We are constantly striving to improve the quality of the services for our members, and our collaboration and communications with other health plans through the MHPA has allowed us to do so."

Prior to his 14 years as UPHP's Chief Executive Officer, Dennis Smith held positions at the Michigan Health and Hospital Association and the MHA Investments Corporation. He received his BS in education from Eastern Michigan University and attended graduate school at Eastern and Western Michigan Universities. The other elected MHPA board members include:

- Chairman, Erhardt Preitauer, President of Horizon NJ Health
- Vice chairman, Jon Cotton, President and Chief Operating Officer of Meridian Health Plan
- Secretary, Catherine Anderson, United Healthcare Community & State's National Vice President of Strategy and Positioning.

"Managed care's role in increasing access for over 70 percent of Medicaid recipients while providing states with budget predictability will continue to grow" said Jeff Myers, MHPA's president and CEO. "It highlights the importance of our being truly representative of the entire industry; that the new officers hail from health plans of varying sizes and business types reflects MHPA's commitment to that."

National Healthcare Decisions Day

Upper Peninsula Health Plan (UPHP), along with other national, state and community organizations, have led the effort to highlight the importance of advance healthcare decision-making. This is an effort that has culminated in the formal designation of April 16 as National Healthcare Decisions Day (NHDD). As a participating organization, UPHP provided information and tools for the public to talk about their wishes with family, friends, and healthcare providers.

"As a result of National Healthcare Decisions Day, more people in our community can have the opportunity to have thoughtful conversations about their healthcare decisions. It is also important to complete reliable advance directives to make their wishes known," said Kate LaBeau, Advance Care Planning Program Manager at UPHP. "Families and healthcare providers will not have to struggle with making difficult healthcare decisions without guidance from the patient. Healthcare providers and facilities will be better equipped to address issues before a crisis occurs. The goal is to be better able to honor patient wishes when the time comes to do so."

National Kidney Foundation of Michigan Brings Health Message to Lansing with Health Award Ceremony

On Tuesday, April 26, the National Kidney Foundation of Michigan (NKFM) held its annual Champion of Hope Tribute Dinner at the Kellogg Hotel and Conference Center in East Lansing. This event honored Michigan organizations and individuals who have been instrumental in helping the NKFM to spread awareness about managing and preventing kidney disease and its leading causes in Michigan.

The annual Champion of Hope Tribute Dinner brought together more than 150 people representing the health care community, state government, and community organizations. This year's Champion of Hope honorees included State Senator Curtis Hertel, State Representative Robert VerHeulen, and Executive Director of the Michigan Association of Health Plans, Rick Murdock. In addition to the Champion of Hope honorees, the NKFM and its partners also presented the Innovations in Health Care Awards for innovative programs related to preventing and managing chronic health conditions. This year's honorees were Priority Health Diabetes Prevention Initiative and the Michigan State University College of Nursing for their screening program for diabetic kidney disease in an underinsured population. Winners were presented with awards and $500. The event also featured an elegant dinner and a raffle of exclusive prizes.

More than 900,000 Michigan adults have chronic kidney disease, and most are unaware. There are little or no symptoms in the early stages and many people are not educated on the risk factors and detection steps they should take. Luckily, about 70 percent of kidney disease caused by diabetes and high blood pressure can be prevented or delayed through early detection, healthy lifestyle changes, and treatment.

HAP pledges support of Flint hometown favorite with 2017 title sponsorship of Crim Festival of Races

Health Alliance Plan (HAP) today announced that it will serve as title sponsor of the 2017 HAP Crim Festival of Races and 2017 HAP Tour De Crim. HAP will succeed HealthPlus as title sponsor following the merger of the two companies last February. Tom Spring, director of wellness and outreach at HAP, made the announcement at a Crim Fitness Foundation news conference. Today's conference serves as the official launch of annual Crim race activities. It was held at One Riverfront Plaza in downtown Flint.

"One of the many benefits of joining HealthPlus and HAP is the opportunity to leverage strong partnerships that continue to foster the health and wellness of the communities we serve," said Spring. "We're delighted to carry on this rich tradition and look forward to building an even stronger bond with the Crim Fitness Foundation and Mid-Michigan."

The HAP title sponsorship is a continuation of a 35-year-old relationship that got its start when HealthPlus employees began staffing the famed Bradley Hills water station and erecting the company's signature red-and- white balloon arch. In 2009, HealthPlus became the Crim's presenting sponsor and, in 2013, was named title sponsor.

Meridian Health Plan Honored with National "Best and Brightest Company to Work For" Award

Meridian Health Plan, for the second time, has been nationally named one of the "Best and Brightest Companies to Work For" by the National Association for Business Resources (NABR). Previously, the NABR had consistently named Meridian as one of "Metropolitan Detroit's 101 Best and Brightest Companies to Work For" 2012 through 2015.

In addition to being awarded "Best and Brightest" both nationally and in Metropolitan Detroit, Meridian Health Plan has celebrated 2015 by earning a spot on the Detroit Free Press "Top Workplaces" list and receiving recognition by the National Committee for Quality Assurance as a top 2015-2016 multi-state Medicaid Health Maintenance Organization (HMO). Meridian earned ratings of 4 out of 5 for all three Medicaid HMO products. The workplace environment and quality reputation has led to phenomenal growth at Meridian, resulting in the hiring of 900 new employees in 2015 and the anticipated hiring of an additional 500 employees by the end of 2016.

The 2015 winning companies were assessed by an independent research firm which reviewed a number of key measures relative to other nationally recognized winners. Those key measures include compensation, benefits and employee solutions; employee enrichment, engagement and retention; employee education and development; recruitment, selection and orientation; employee achievement and recognition; communication and shared vision; diversity and inclusion; work-life balance; community initiatives and strategic company performance.

Meridian Health Plan was featured in the January 14th on-line edition of Corp! Magazine and will be recognized as a national winner at a "Best and Brightest Companies to Work For" award symposium and gala in Detroit.

With more than 20 years of experience conducting Best and Brightest Company competitions, the National Association for Business Resources (NABR) have identified numerous best Human Resource practices and provided benchmarking for companies that continue to be leaders in employment standards.

Health Alliance Plan Selected by CMS for Initiative Promoting Better Cancer Care

Health Alliance Plan was selected by The Centers for Medicare & Medicaid Services as one of 17 health insurance companies to participate in a care delivery model that supports and encourages higher quality, more coordinated cancer care. The Medicare arm of the Oncology Care Model includes more than 3,200 oncologists and will cover approximately 155,000 Medicare beneficiaries nationwide.

The Oncology Care Model encourages practices to improve care and lower costs through episode- and performance-based payments that reward high-quality patient care. The Oncology Care Model is one of the first CMS physician-led specialty care models and builds on lessons learned from other innovative programs and private-sector models. As part of this model, physician practices may receive performance-based payments for episodes of care surrounding chemotherapy administration to Medicare patients with cancer, as well as a monthly care management payment for each beneficiary. The two-sided risk track of this model would be an Advanced Alternative Payment Model under the newly proposed Quality Payment Program,which would implement provisions from the Medicare Access and CHIP Reauthorization Act of 2015.

Practices participating in the five-year Oncology Care Model will provide treatment following nationally recognized clinical guidelines for beneficiaries undergoing chemotherapy, with an emphasis on person-centered care. They will provide enhanced services to beneficiaries who are in the Oncology Care Model to help them receive timely, coordinated treatment.

The names of those practices and payers participating in the Oncology Care Model, and more information about the model, can be found on the model's website:http://innovation.cms.gov/initiatives/Oncology-Care/. The Oncology Care Model begins on July 1, 2016 and runs through June 30, 2021.

Meridian Health Plan and Food Bank of Eastern Michigan Team Up to Feed Thousands of Flint Families through September

The Food Bank of Eastern Michigan (FBEM) and Meridian Health Plan announced a partnership to provide the residents of Flint with free, healthy foods high in iron, calcium and vitamin C. These nutrients help mitigate the effects of lead in the body caused by high levels of lead in the Flint water supply.

Last month, FBEM instituted a new program featuring four large, refrigerated delivery trucks that will each deliver 15,000 pounds of fresh food per day – enough for 400 families – six days a week. Governor Rick Snyder's recent supplemental budget request will cover the cost of the delivery trucks and food, while Meridian assists with additional operational costs.

Meridian has partnered with FBEM, Food Bank Council of Michigan, and the Michigan Department of Health and Human Services to lend additional financial support for two of the trucks in a program called, "Fueling Food for Flint." The four trucks are expected to deliver almost 12 million pounds (320,000 meals) of additional nutritious foods to Flint residents through September 30.

In March, the Meridian Winter Blast festival in Detroit raised $50,000, $40,000 of which came from Meridian for the Flint Child Health and Development Fund. Meridian also plans to donate fresh fruits and vegetables from the 500-acre Cotton family farm in Metamora, Mich.

Hamilton Community Health Network Partners with Meridian Health Plan For Flint Water Crisis Health Education Days

Flint Water Crisis Health Education Days brings physicians, nutritionists, food demonstrations, free nutritional food giveaways, water filter cartridges and bottled water distribution to the City of Flint. This family-focused series provides education on lead poisoning from healthcare professionals on how to reduce levels of lead in the body.

The first event, hosted Tuesday, March 8, 2016 at the North Pointe Clinic brought together community members to participate in educational seminars, activities for children and giveaways. Meridian Health Plan donated and passed out more than 350 bags of food to all individuals who attended the event and to the Hamilton Community Health Network and Food Bank of Eastern Michigan.

"Through our 'Fueling the Food for Flint' initiative and partnering with Hamilton Community Health Network for Flint Water Crisis Health Education Days, we are able to educate Flint community members on both the effects of lead and the power of nutritious food," said Jon Cotton, president and COO, Meridian Health Plan. "It is very important to work in the Flint community at this time, as we can make a lasting impact on the health and wellness of Flint residents."

Making the connection: oral health and literacy

Attendance plays an important role in school success, especially in the early grades where basic math and reading skills are taught. Children miss 51 million hours of school each year due to oral health issues. We are committed to doing our part to ensure that children show up for school every day healthy, pain-free and ready to learn. Our message to children is simple: 2x2+20 — Brush your teeth two times a day for two minutes each time and read for 20 minutes a day for a healthy body and mind.

Here's what Delta Dental is doing to promote the importance of good oral health and daily reading during National Reading Month in March:

- Delta Dental provided legislators with more than 1,500 classroom tote bags to use when visiting first-grade classrooms around the state. Tote bags contained books, bookmarks, toothbrushes, reading and brushing logs, teacher lesson plans and science activities.
- We're hosting a series of preschool oral health story hours at Capital Area District Libraries.
- Delta Dental employees are reading in elementary school classrooms, taking tote bags full of oral health goodies and books for the children and their teachers.

Funding from Delta Dental to improve children's oral health in Flint

Two Delta Dental Foundation grants will help address the oral health needs of children in Flint. The grants, totaling $204,302, were awarded to the Michigan Department of Health and Human Services and will fund two school-based fluoride programs.

As a result of the water crisis, children in Flint – especially those under the age of six – are drinking more bottled water and may be drinking more juice and sugar-sweetened beverages, resulting in lack of fluoride. The new programs are designed to help Flint students receive the daily benefits of fluoride to protect their teeth from cavities.

The first program, a school-based fluoride rinse, will serve up to 6,000 children in the Flint area and began June 1 for students enrolled in Flint Community Schools' summer programs. It will expand to other schools in the Flint area beginning this fall.

The second is a fluoride varnish program, which will begin in the fall and serve up to 2,000 students attending Head Start programs in Genesee County. Both programs will be run by Mott Children's Clinic and will be evaluated for effectiveness by the University of Michigan Child Health Evaluation and Research Unit.

Following the announcement of the programs at Doyle/Ryder Elementary School in Flint, students were treated to a performance of the oral health musical, "I Need My Teeth," offered by Indiana-based McMillen Health and funded by the Delta Dental Foundation. The performance focused on the importance of taking good care of your teeth.

Connecting the dots: oral health and hunger

Recognizing the strong connection between hunger, oral health, and school and life success, Delta Dental of Michigan has announced a philanthropic partnership with Forgotten Harvest – one of the nation's largest food rescue organizations.

Delta Dental's contribution of $237,000 will ensure that underserved children in metro Detroit receive much-needed food throughout the year as part of three programs – the Forgotten Harvest School Pantry Project, the Forgotten Harvest Million Meal Challenge for the Kids Summer Feeding Program, and the Forgotten Harvest Detroit Public Library-Children's Feeding Partnership.

The two organizations will also work together to help educate children, families and those who work with children about the importance of good oral health, healthy food choices and the Healthy Kids Dental program, which is available to Medicaid-eligible children ages 0-12 in Wayne and Oakland counties, and ages 0-21 in Macomb county.

In addition to its financial contribution, Delta Dental will send a team of 35 to 50 employees to Forgotten Harvest each month through November to help package food for distribution.

To learn more about this partnership, watch a short video on our YouTube channel by visiting http://bit.ly/1UtML3n.

Fidelis SecureCare Announces Charitable Donation to Support Valley Area Agency on Aging Services

Fidelis SecureCare, a Southeast Michigan-based Medicaid health plan today announced a donation to Flint based Valley Area Agency on Aging. The donation, made possible by the Centene Charitable Foundation will fund health and nutrition programs for seniors affected during the Flint water crisis. Earlier this year, Fidelis SecureCare donated bottled water and baby wipes to Flint's El Shaddai Ministries to support the daily needs of seniors while water quality concerns existed.

Fidelis SecureCare is located in Troy and provides health insurance services to those eligible for both Medicare and Medicaid in Macomb and Wayne counties. Williams said that company employees have regular conversations about opportunities where help is needed, and that Flint area senior concerns are a consistent theme.

Valley AAA has been intimately involved in supporting senior health and wellness concerns since the Flint water system concerns first surfaced. The organization continues to offer homebound seniors with bottled water delivery, and a nutrition and health check program now is in place to ensure long term effects of lead ingestion are minimized.

MedEncentive Earns U.S. and Canadian Patents on Health Reform Breakthrough

MedEncentive, LLC, a leader in the area of healthcare cost containment, announced today it has received two new patents covering the company's "trilateral health accountability model™." The U.S. Patent and Trademark Office issued U.S. Patent No. 9,171,285 and the Canadian Intellectual Property Office issued Canadian Patent No. 2,729,553 to MedEncentive.

Founded in 2005, MedEncentive offers web-based population health services designed to improve health and healthcare in a manner that controls overall healthcare costs, a challenging objective that population health experts referred to as the "triple or three-part aim."

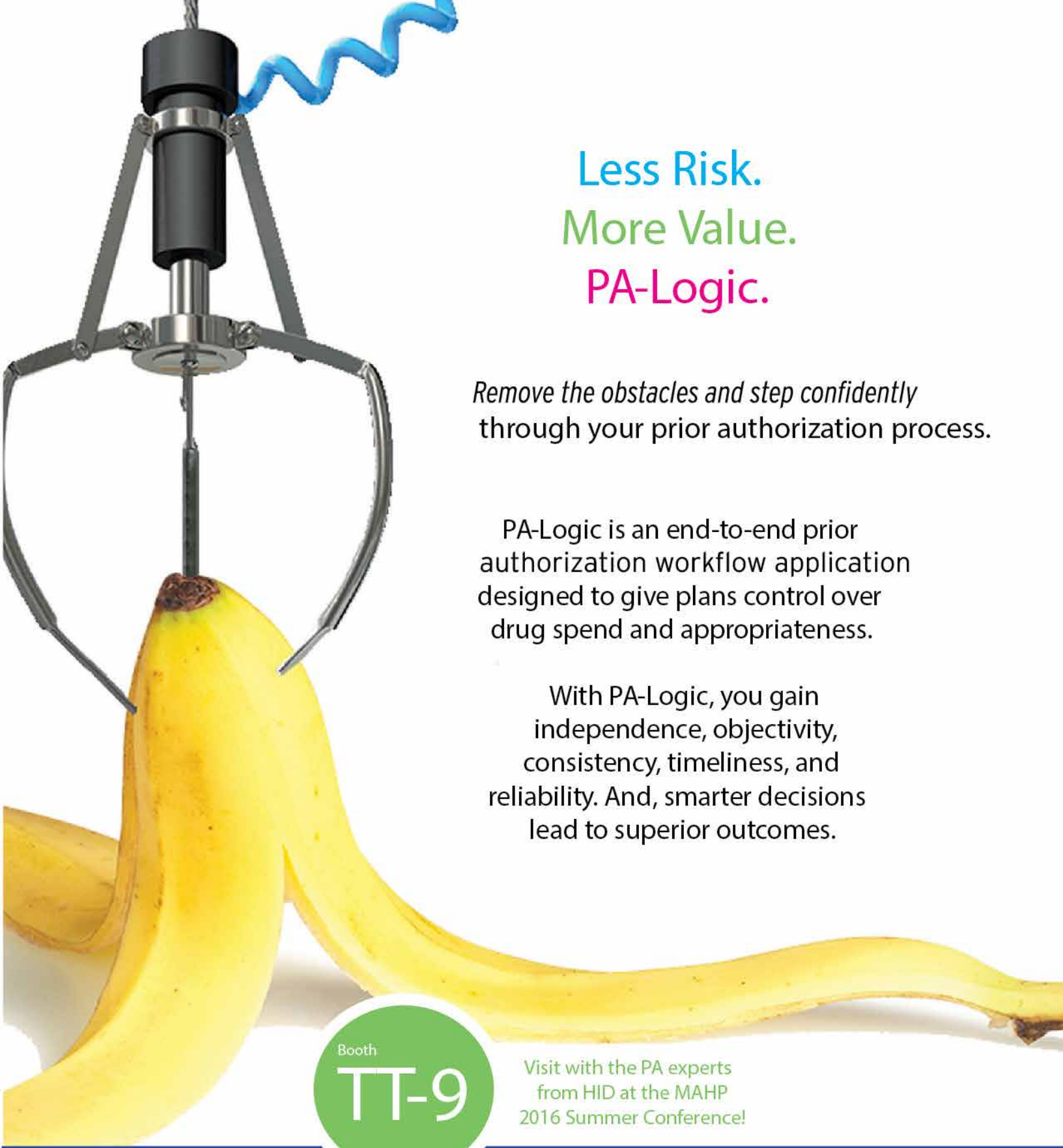
"The 'trilateral health accountability model' is at the core of MedEncentive's program," said Jeff Greene, MedEncentive CEO and co-founder. "In effect, our program achieves the 'triple aim' by financially rewarding both doctors and patients for declaring or demonstrating adherence to best clinic practices and healthy behaviors, provided the parties agree to allow one another to confirm or acknowledge their adherence. This method of 'checks and balances,' coupled with the use of 'information therapy' to advance patient health literacy, is a novel approach to population health that is claimed in the issued patents."

Former U.S. Senator, Tom Coburn, M.D. says, "I believe this program is creative, innovative and has enormous potential to improve health care delivery and outcomes, while also reducing costs." Dr. Coburn adds, "As a physician, I especially like how the program improves patient health literacy, promotes doctor-patient mutual accountability, and provides a means for doctors to exercise their clinical judgement in the use of evidence-based treatment guidelines."

The State of Oklahoma and MedEncentive are currently testing the program in one of the largest health improvement/cost containment (triple aim) experiments ever attempted in the U.S. The preliminary results of this three-year cohort study, among public sector employers and school districts, are very encouraging in terms of reduced hospitalizations, emergency room visits, cost savings, and return on investment. The study's final results should be released by mid-2017.

"The fact that we would be willing to put our invention to the test in this very public trial, speaks to our confidence that our program is uniquely effective at controlling healthcare costs," said Susan Chambers, M.D., MedEncentive co-founder and acting medical director.

"Since there have been so many failed attempts by others to reform health and healthcare, we are intent on taking a measured approach that relies on scientific methodology in these public demonstrations," continued Greene. "Once we gain consensus among population health experts that our program does, in fact, solve the 'triple-aim,' then our patents will help the company move quickly from proof of concept to widespread commercialization."



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Controlling Specialty Drug Spend through the Coverage Determination Process

According to United Health Center for Health Reform and Modernization, the United States spent $87 billion on specialty drugs in 2012 — that number is estimated to reach $400 billion by 2020. In 2014 alone, the cost of specialty products alone has risen 13.1 percent Specialty drugs now cost more than the median household income.

The rise in the use of these drugs has dramatically changed the healthcare industry and the drug therapy landscape. Change is particularly evident in regards to authorizing and paying for these types of drugs. Specialty drugs often require special handling and increased monitoring.

Approximately 30 percent of a plan's pharmacy costs are represented by less than 1 percent of all prescriptions. And, this is a number on the rise exponentially. For example, nearly 70 million Americans have a diagnosis of hyperlipidemia. Without appropriate controls in place, any of these patients has the potential of receiving a script for one of the new PCSK9s—Praluent® (alirocumab) or Repatha® (evolocumab)—which may cost up to $14,000 annually. Research studies show, though, that nearly 80 percent of these patients could benefit from traditional statin therapy at a cost of $250 per year. Similarly, new drugs like Copaxone® for treatment of multiple sclerosis costs payors $80,000 per year. While only two percent of the population is affected by this disease, traditional therapy costs $13,000 annually, on average. This is a 615 percent increase in pharmacy cost for one script for one patient for one year. In five years, pharmacy spend is expected to increase to nearly 50 percent of healthcare expenditures. It is more important than ever to control pharmacy costs without sacrificing high-quality healthcare and appropriate therapy regimens.

Here are three important ways to control the costs of specialty drugs:

1. Ensuring alternative therapies are tried first.

For some chronic health conditions, treatment with a specialty drug for one year can cost $100,000 or more. That's an unsustainable trend, especially since the median American household income is more than half of that figure. One of the most efficient ways to bring down the cost is the implementation of step therapy guidelines, within the coverage determination process, to require that less expensive, alternative therapies are tried and failed prior to prescribing the newer, more expensive drug.

While new specialty drugs for many orphan conditions are being released without previous, current market alternatives, there are current therapy options for many other specialty drugs, such as Enbrel® and Humira®. Standard clinical practice guidelines from the American College of Rheumatology even recommend such conventions. While the new specialty medications may be essential for successful, efficacious treatment of some patients, this method of controlling costs should be managed on a case-by-case basis. The plan's coverage determination process should stipulate the conditions by which a lower cost, but evidence-based alternative therapy should be required and the requirements for allowing approval of the higher-cost drug.

2. Strengthening coverage determination rules.

Try and fail coverage determination rules are often implemented to control the cost of specialty drugs. This means a patient must try one or more inexpensive drugs before the cost of a more expensive prescription will be covered. These business rules are often referred to as step therapy edits.

Implementing step therapy edits can be used to build a patient's medical profile, as well as a way to more effectively monitor treatment. Since more expensive price tag does not always mean better outcomes, in many cases, it simply makes sense to start with a less expensive drug.

Another cost-effective approach that would fall under determination rules would include a partial fill requirement for expensive specialty drugs whereby the quantity of medication approved for the patient is initially limited to only a portion of the treatment period, say 30 days, in order to see if the medication is actually effective for that particular patient and to ensure that patients are following treatment guidelines appropriately.

Additionally, prescription abandonment rates comes into play when building coverage determination rules. According to the Journal of Managed Care pharmacy, more than 1 in 4 members abandon prescriptions costing more than $200 per month. The abandonment rate increased exponentially as the monthly cost of the prescriptions increased above $100. Odds of abandonment for prescriptions over $500 is seven hold higher.

3. Creating a comprehensive program.

A comprehensive coverage determination program provides health plans with the necessary tools to control specialty drug spend. This also includes independent and objective oversight so there is no relationship with drug manufacturers and a process is in place that allows decisions to be made in a systematic algorithm-based manner. It is important to work with an independent, objective, clinical services company that provides sound expertise and data-driven information.

For a plan to strategically increase control of the coverage determination process while ensuring therapy appropriateness, it must have an independent and objective partner who is focused appropriately. A dedication to deepening the strength of coverage programs is essential to maximize plan efficiency, auditability and consistency, reducing administrative burdens for all stakeholders. Commitment to these principles means expanded criteria sets, lower approval rates, improved data access, proven regulatory compliance, and decreased ingredient cost for a healthier bottom-line.

MAHP Legislative Reception

MAHP's annual legislative reception, held on Tuesday, April 19, gave members an opportunity to discuss key issues facing the industry with a variety of lawmakers, House and Senate, Republican and Democrat. Held at Troppo's in downtown Lansing, the event was well attended by key lawmakers and representatives from the Snyder Administration as well as leaders from health plans across the state, providing valuable face-to-face communication that will prove useful as the MAHP legislative agenda moves forward.

Senator Dale Zorn with Kellie Rice and Danielle Devine of Meridian Health Plan

Mehrdad Shafa, MD, Harbor Health Plan, Pat McPharlin, DIFS, David Bilardello and Mary Deluca of Priority Health

Jim Forshee, MD of Molina Healthcare, Senator Jim Marleau and Karen Jonas, MAHP Consultant

Representative Dave Pagel, Heidi McGlinnen, Bryan Cole and Tiffany Stone of Molina Healthcare

Senator Peter MacGregor, Mary Deluca, Priority Health, and Judy Hooyenga

Dusty Fancher and Senator Goeff Hansen

Joyce Poole, Representative Wendell Byrd, and Beverly Maison of Harbor Health Plan

Joyce Poole, Kimberly Hollbrook, Beverly Maison, Representative Leslie Love, Vanessa Brown-Frank and Mehrdad Shafa, MD of Harbor Health Plan

David Bilardello, Priority Health, Represetnative Jon Bumstead and Jon Smalley

PJ Pettipren, David Bilardello, Priority Health, and Senator Rebekah Warren

Senator Tom Casperon and Steve Mitchell

Senator Patrick Colbeck and Rick Murdock

Chip Amoe, Kim Ross, Representative Daniela Garcia and Rory Lafferty

Representative Lana Theis and Matthew Walsh of Health Alliance Plan

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Thursday, November 3, 2016
MAHP Foundation Best Practice Forum
English Inn