Sellers Dorsey Report
Interview with Thomas L. Johnson of Medicaid Health Plans of America
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Welcome to the Sellers Dorsey Report. I am your host, Kip Piper.

Today's edition is about Medicaid health plans. Chris Labonte of the Sellers Dorsey team interviews Thomas L. Johnson, executive director of Medicaid Health Plans of America. Mr. Johnson talks about how health plans serve Medicaid beneficiaries, changes in the marketplace, and new issues in state and national health reform.

These podcasts are courtesy of Sellers Dorsey, leading experts on Medicaid and state and federal health reform. On the web at SellersDorsey.com.

And now Chris Labonte's interview with Thomas L. Johnson, executive director of Medicaid Health Plans of America.

Chris Labonte: Well thank you very much, Thomas. Please, why don't you tell us a little bit about Medicaid Health Plans of America.

Thomas Johnson: Sure. Our organization actually has been around since 1993. We were formed in Los Angeles, California. A gentleman by the name of Dr. Clyde Oden was the original founder and we opened our Washington offices in 2001. Originally, we were called the National Association for Urban Based HMOs and we focused on urban issues and HMOs in urban areas. We changed our name in 2004 because we wanted to reflect the focus of the organization being on Medicaid. And so we did that October 1, 2004, a month actually after I started as Executive Director. So our focus has been very clear about representing Medicaid health plans, representing interest pertaining to Medicaid, looking at issues relating to CHIP because a lot of those programs are integrated. And so we have been very, very clearly focused on that since we changed our name five years ago.

Chris Labonte: Great. What do you think ultimately distinguishes your member health plans from the larger universe of health insurers in the employer or government sponsored business?

Thomas Johnson: I think that the major thing is that we serve enrollees that are poor. So we can't charge any premiums and thereby we assume all of the risk. You know whether our enrollees are sick or healthy you know our plans receive a capitation amount based on certain assumptions. So, unlike our commercial counterparts or those that do business with the government for government employees or others. We assume 100% of the risk. So the profit margins for our plans because of that and because of the challenge and health indices that they face with their enrollees they tend to be a lot smaller than a lot of our commercial counterparts. But I think the people in the industry are very committed to the people that they serve. They know going in that there are going to be challenges with this population. There will be health challenges, there will be challenges as far as compliance is concerned, there are a lot of state regulations in addition to the federal regulations that our plans have to comply with. And there are a lot of issues that relate to cultural competency that are really unique for Medicaid health plans and the enrollees that they serve. So those are some of the challenges that the plans deal with.

Chris Labonte: Do you see part of your role here at the Medicaid Health Plans of America as sort of educating and helping your members deal with some of those unique needs of those plans whether it be cultural competency, dealing with chronic conditions or the like?

Thomas Johnson: Absolutely. One of the things that we do that is very popular with our membership is that we pull together a compendium of best practices in the industry. And that way plans are able to see practices that others are engaging in various clinical areas where there are positive outcomes. It is also a way for us to show the value of Medicaid health plans to state legislators, state governments. Those are the entities where our plans contract with. So clearly because they are putting a lot of money into the system they want to get value for their investment. So that tends to be a very popular product that we put out. And it's a chance for plans to really share information, see what each other is doing and apply some of that to their own practices and the various states they do business in.

Chris Labonte: Right. You may have actually just answered this question. I'm going to ask it anyway. You mention states and obviously states right now are going through tremendous difficulties with state budgets, tax revenues are down, enrollment for both Medicaid and CHIP continually goes up and payment rates are being capped or even cut in some instances. How are your health plans, your member plans adapting to this difficult state fiscal environment?

Thomas Johnson: Well it's challenging. I think any provider of any type that is doing business in Medicaid right now feels the affect of what is happening at the state level. The downturn in the economy is having two affects, on the one hand, it is putting a lot of pressure on state budgets they are having a hard time coming up with revenue to meet their goals and a lot of times they are having to cut back on a lot of services that they provide including Medicaid. On the other hand, because of the fact that the unemployment rates are up you see more and more people actually getting on Medicaid. So in many cases enrollment is actually up in Medicaid. Enrollment is up in our industry. We actually have 57% of all Medicaid enrollees are in a capitated plan across the country.

Chris Labonte: Wow, 57%, wow that's much higher.

Thomas Johnson: And 70% overall are in some form of managed care. This is the first time, actually, in the program's history that that 70% number has been reached and so we're definitely seeing more enrollment. We expect that we are going to continue to see that for some time. There are some states still that are actually looking at Medicaid Managed Care as a solution to their problem. What they are doing is they are putting more and more of their populations into managed care they are expanding their programs. Georgia is a perfect example of this. They have put almost all of their Medicaid eligible into managed care. Very aggressive program, very aggressive ramp up for their program, they are seeing some savings from what they originally had where they had enrollees in fee for service in certain categories. So we think we can offer a solution to states and that is what we try to do on a day to day basis.

Chris Labonte: So in Georgia for instance, if I can just ask a question about that you know, there are obviously full risk plans but also you know, things like primary case management or EPCCM (enhanced primary care case management) programs that also sometimes qualify under "managed care" and when you are talking in Georgia you are talking about all of those different types of programs or just the capitated full risk?

Thomas Johnson: Actually, Georgia really moved towards putting the vast majority of their population in the full capitated model and there are studies that have shown that their model is the one that is going to get you the savings. Our belief also is that it is going to provide the most coordinated care as well, which we think is very important for a population.

Chris Labonte: You often meet with governors and state Medicaid Directors and other senior officials to discuss Medicaid managed care and sort of the value that it can bring to a state and to its beneficiaries. How do you often describe the business case for states to either use or increase their contracting with Medicaid health plans?

Thomas Johnson: I think there are a couple of areas first and foremost, as I indicated before, they are looking to save money. Every state is dealing with this issue in some fashion. If you look at the passage of the American Recovery and Reinvestment Act (ARRA) part of that included a temporary increase in the FMAP (Federal Medical Assistance Percentage). Without that taking place, we think governors would have it even much worse now in terms of meeting their Medicaid needs than they currently have. But we have been able to show in a number of states where we have been able to save money over a period of time if populations are put into managed care. Over an eight year period, Massachusetts has saved about $1.5 billion by putting a lot of their population into Medicaid managed care system. Pennsylvania over a similar period of time has saved $2.7 billion by accomplishing the same. And the good thing is that because that care has been coordinated you have seen positive health outcomes as well through a coordinated system. We think anyone who is purchasing this type of care is looking for both; looking for savings and looking for efficiencies and they are also looking for outcomes they are looking for what they are buying, they want a value for it. We think that we have been able to offer that in a vast majority of states that we have a strong presence in.

Chris Labonte: You mentioned the two sides of the coin in terms of what states are looking for one is to sort of help contain costs but also to make sure that they improve quality. And I know that Medicaid health plans really have been innovators in the past in this area. What are your health plans doing now to address state needs for things like chronic care management, patient-centered care delivery and the like?

Thomas Johnson: Let me mention just one positive outcome that we documented in our best practices compendium, Passport Health Plan in Kentucky engaged in a very strong screening program for EPSDT (early periodic screening, diagnosis and treatment) in 1997 they had a rate of 17% compliance. They engaged in a program giving providers incentives to follow certain protocols, that rate over a nine year period went up to 93%.

Chris Labonte: Wow, that's amazing.

Thomas Johnson: That's a success story that we like to talk about. When you see care coordinated, when you see strong disease and care management that takes place, that is one of the things that we like to highlight in our compendium that we produce every year. We also think that as a lot of states are looking at medical home concepts. The fact of the matter is we are the most complete medical home model that exists. What concerns me with the medical home concept is that a lot of them add an administrative fee of some type as part of the management of the care of that individual. We're not asking for that. We're asking to be paid fairly and be paid according to how regulations state we

should be paid. But we are not asking for an additional administrative cost to do that. So I think our model with regards to dealing with chronic care actually has shown to be a much more efficient model than some of the other models that are out there trying to fill that role. Chronic diseases are something that we deal with everyday. And I think those who are aware of the intricacies of dealing with chronic diseases know that we have the systems in place, the coordinated systems in place to address the needs of that population.

Chris Labonte: One of the huge populations that often grapples with chronic care and managing are the dual eligibles is just huge, 7 million highly vulnerable beneficiaries such as using a disproportionate amount of healthcare dollars about I guess $300 billion worth of both Medicaid and Medicare services. There is obviously a growing interest among policy makers to create and integrate Medicaid and Medicare plans that serve these dual eligibles to help better coordinate and manage this care. How do you see this playing out over the next couple of years?

Thomas Johnson: Well I will tell you this, first when the Medicare Modernization Act went into place we saw a number of our plans create special need plans that were outlined in the legislation they went into that market because of that very issue. They have experience with that population that they felt they could bring over to Medicare. And they have been successful in doing that. We have also produced a study that we have been pushing for quite some time that shows if you really look to integrate care with that population in a capitated setting you can potentially save $300 billion over a 12 year period of time by fully integrating care in that capitated model. We have that study on our website, it is available for people to download.

Chris Labonte: Would we be able to link to it from our website?

Thomas Johnson: Absolutely. Absolutely. But it is a very, very important issue I think as we move forward. I think the federal government all states are dealing with this specific issue. We think that integration is the key to savings.

Chris Labonte: In addition to special programs that deal with dual eligibles, are there other market opportunities that you see that your plans have today in going forward over the next decade or so?

Thomas Johnson: Well I think health reform is going to determine part of that. You have obviously got a large population that is uninsured. From the proposals that we've looked at it appears that if there is some type of Medicaid expansion we think conservatively speaking you are probably looking at 10 to 20 million potential new enrollees in Medicaid. So there are some obvious opportunities there. I think if the federal government starts to look at how they deal with other populations in Medicaid, the blind and disabled population, SSI population, the

TANF population some of those categories that are not capitated there are some definite market opportunities there also. I think also if this health exchange is created under health reform there may be some additional opportunities in this market as well. So I definitely think that there are market opportunities for plans to enter into this business.

Chris Labonte: You mentioned earlier this got me thinking, you mentioned earlier the sense that your plans obviously have a unique skill set in terms of dealing with the population, Medicaid population. Do you envision more commercial players who haven't heretofore participated in Medicaid trying to enter that marketplace?

Thomas Johnson: It's hard to say. We have seen I would say especially over the last 10 years you have seen a growth in a number of very large publicly traded companies that are in the program. I think on the other hand because of the struggles the states have had especially over the last five years you have seen some hesitancy. So it is hard to say if there is a pattern or not. For every commercial entity that has entered into the market that is some of our larger members, Aetna is also in the market as well, you've seen some entities also leave the market because it is a very difficult population to deal with especially if you do not have the experience and the dedication to stay with dealing with that population. You know, understanding that you have got to assume all the risk and you can’t increase premiums. You are very reliant on the states to pay you an actuarially sound rate. Our plans have to be very innovative in the types of models that they put into place to manage this population. So I think if plans are not flexible in doing that and they don't have that deep down commitment I think commercial plans are probably hesitant.

Chris Labonte: I guess the flip side of that question obviously is whether or not the plans that are members of your association, whether or not they would be interested in diversifying going over to the commercial side or entering the Medicare marketplace.

Thomas Johnson: Well I think you have seen some evidence of you know, entering into the Medicare market through their involvement in the SNPs (Medicare Special Needs Plans). Outside of that I have not seen a further extension overall. It doesn't mean that it might not happen. But generally speaking I think our plans are very mission driven in terms of dealing with the populations that they serve, especially the Medicaid only plans.

Chris Labonte: Right. I think you know, perhaps the national healthcare reform through some of these exchanges there may be opportunities for Medicaid plans to sell products to the subsidized population. For instance, within there. Which may be more akin to serving Medicaid population than they would be the traditional commercial marketplace.

Thomas Johnson: Absolutely. And I think it all depends on what the standards are for the exchange once they are developed fully and again, assuming that some type of health reform measure passes. I think our plans will look at that market.

Chris Labonte: In the executive suites in board rooms of Medicaid plans today what do you think people are saying about the opportunities and challenges in the marketplace?

Thomas Johnson: I think clearly there are challenges from a rate setting perspective. Especially if you are in certain states that are having severe fiscal problems, California, New York, Michigan, all having very severe fiscal problems. Louisiana is right behind, a number of other states are probably in the same category. So that is something that you have got to be prepared for. And I think that people in board rooms in those markets are definitely talking about that. I would say also that they're excited though because we think that we can make a contribution to health reform. And even though there is a lot of bickering going back and forth processes in effect I think our plans see a lot of opportunities there. And I think that they are excited about that. I think they have something to contribute. You know, we distinguish ourselves in a lot of ways from our commercial counterparts. Because of the mission driven emphasis that our plans place on what they do on a day to day basis. So you know, I think on a day to day basis they know about the fiscal challenges. But on the other hand I think they see a lot of opportunity as well.

Chris Labonte: Speaking about that opportunity and I guess a big unfortunately I don't have my crystal ball with me today, Thomas, but you know I think with national healthcare reform will come opportunities and challenges across the spectrum in terms of the healthcare marketplace and the environment. And doing a little research prior to coming here to talk to you, we noticed you had identified about 11 recommendations for national healthcare reform. And without going through all of them I was wondering if you could just identify it is always difficult to prioritize but maybe identify some of the top priorities for the association during national healthcare reform.

Thomas Johnson: Sure. I would focus on three areas, I think we focus on three areas. First, definitely the opportunity for there to be the expansion of the Medicaid market. Having people be more eligible, having them have some kind of health coverage. I think that is a definite focus for our organization. Both the House and the Senate have talked about expanding those that would be eligible to a certain percentage of poverty. So I think that there is a strong focus for us there. I would say that there is a general focus about funding in two specific areas. We are trying to get a provider tax that goes to HMOs in certain states. That tax is set to expire October 1, and we are trying to get that tax extended for at least a couple of years. That's a high priority for us. Some of the states that I

mentioned that are having some of those severe fiscal problems.

Chris Labonte: I know my home state of Pennsylvania is one of them.

Thomas Johnson: Pennsylvania is one, yes. California is one; Michigan is one; that is something that we have set as a priority. Generally speaking we would like to see this administration take a more active role in making sure that the actuary soundness requirements are in force in the proper manner. We thought that the previous administration was not active in doing that in many cases. So that will be a priority for us throughout health reform and throughout implementation. Finally, there is a issue called Drug Rebate Equalization Act that we have been supportive of that would extend the drug rebate that currently exists on the fee for service side on Medicaid. Extend them to managed care organizations. The rebate was established in 1990 when the penetration of the market was less than 10%. Now it is at 70%. And so we would like to see that rebate extended so we can continue to coordinate the care of our members and not have their care divided potentially between two carriers. That is a very important issue for us.

Chris Labonte: Has discussion of that particular policy issue been part of the national healthcare reform debate or I would assume there is a separate piece of legislation that is moving forward. How are your efforts trying to include that legislation within national healthcare reform?

Thomas Johnson: We have been successful with getting legislation included in HR 3200 (House health reform legislation). That is in the House bill. All indications are that Senate Finance is looking at that issue very strongly. So we think we got some positive signs. Our organization also leads a coalition called the Partnership for Medicaid. It is a group of 20 different provider related groups and other groups that look at Medicaid as a priority. And most of the members of that group have supported the Drug Rebate Equalization Act. Some of the support we have got includes support from labor unions, American Public Health Association, other types of national provider groups. The National Governor's Association has supported this extension.

Chris Labonte: So some big names who are involved in national healthcare reform.

Thomas Johnson: Exactly. So we think we got some broad based support for it. We had support in the last Congress from Rahm Emanuel on the House side, and so President Obama actually called for it when he released his budget earlier this year. So it is something that is a priority for us.

Chris Labonte: One of your recommendations also centers around long term care which we haven't really talked about and I think is probably not something that comes potentially top of mind to people when they think about Medicaid health plans.

What role do you think Medicaid health plans play in long term care now? And I think the follow up is what role do you think they should play in the future?

Thomas Johnson: I think they can play a strong role in addressing some of the long term care concerns. Long term care is driving a lot of cost in Medicaid. Even though currently we have over half of the enrollees in capitated programs. Cost wise you are only talking about 20% of the cost of the program. Conversely, about 20% or so are in long term care but it takes up over 50% of the cost of the program. So we think there is a role out there for us. There would have to be some regulatory changes and focus certainly that will have to be taken into account in terms of how we would get reimbursed overall for coordinating that care. But we think we can definitely play that role. I think the PACE program actually is a very good example of a program very similar to managed care where care is coordinated or you have seen positive results in long term care challenges. So we think we can take some of those examples and apply it to a capitated model.

Chris Labonte: Well, national healthcare reform legislation could bring new opportunities as we've talked about, obviously brings new risks and challenges. For example, the House health reform bill which we talked about earlier, HR 3200, includes new expectations including an extensive Federal regulation of health insurers and federal review of the adequacy of HMO rates paid to providers. MACPAC which is the new Medicaid and CHIP Payment and Access Commission has a broad mandate to examine Medicaid and CHIP issues. Are there specific parts of healthcare reform legislation either in the House bill, Senate health bill of what you have heard there is going to be in the Senate Finance bill that concern you?

Thomas Johnson: Let me mention two other issues that I haven't raised before with regards to health reform that have come up under the current discussions. In the House bill there is a provision that we are concerned about that would set a medical loss ratio amount. We think it would be an artificial amount where plans would have to use a certain amount of their premium dollars for care and they would be limited in using a certain amount of their premium dollars.

Chris Labonte: Is that in statute or is it a regulatory scheme that sets the ratio?

Thomas Johnson: This actually is a proposal that is included in HR 3200. There is a section that specifically applies to Medicaid health plans and we think that that goes against the grain of actuarially soundness. That really is when you have a strong actuarially sound system and rate setting process that really takes care of itself because the actuaries look at medical trend costs other types of costs and admin costs and overall that hasn't been a problem in the rate setting process. There are some states that have this type of provision, they actually have some exceptions in certain areas. New York has a marketing exception where health plans are able to market to try and bring in enrollees. This federal provision

does not have that so you are looking at a potential one size fits all solution to a problem that we don't think exists. So we have some strong concerns about that section. In the reform legislation also, essentially the CHIP program a program that we have been very supportive of we were very strong advocates to see it, we not only authorized but expanded it, would actually come to an end in a couple of years if health reform is enacted this year. I frankly we have some very strong concerns about that as well. As to a lot of other provider groups that were in support of the CHIP program there were a lot of incentives, a lot of bonus payments, a lot of grant funding, a lot of things that advocates were looking for that would go away in HR 3200. We would not like to see the CHIP program go away. So that is another concern that I would say that we would have that currently exists in that legislation.

Chris Labonte: So given that Thomas, obviously if the chairman in the House and Senate committees were dealing with this, if Senator Baucus was sitting in this room with us, what would you ask him to do to make sure that your member plans were adequately covered in healthcare reform?

Thomas Johnson: What I would say to Senator Baucus and to Representative Waxman is that as we have been partners in the various states that we do business with we can be partners to both of them as well. We can be part of the solution not part of the problem. It is not going to help if certain groups or certain people are vilifying the industry. We don't think that that is a positive way to look at health reform. That should not be taking place. What we should be looking for are solutions to making sure that more people have access to healthcare and it is done in a cost effective manner. And the fact of the matter is we can claim credit in both areas as well as providing quality healthcare. So we can provide solutions we think to the goals that they are trying to accomplish. Our partnerships have been very strong in the states, we think we can be an even stronger federal partner but we shouldn't be vilified for doing the good work that we have been doing.

Chris Labonte: Is there anything else you would like me to ask you?

Thomas Johnson: For those who are interested, we have an annual meeting every year and we are having our fifth annual meeting this year November 16 and 17 in Washington D.C. At the Fairmont Hotel and information on the meetings on our website you can go to www.MHPA.org and find out information. We have former HHS secretary Tommy Thompson is one of our keynote speakers. We have President Obama's former presidential campaign manager, David Plouffe as a keynote speaker. And we also have Mark Shields who appears as a regular columnist on the News Hour with Jim Lehrer as a keynote speaker as well. We encourage people, if they want to find out more about the industry and meet leaders in the industry to attend the meeting.

Chris Labonte: Sounds like a great meeting and a great time to have the meeting particularly

with all that is going on in Washington D.C. So thank you very much, Thomas. We appreciate it.

Thomas Johnson: Thank you.

Chris Labonte: Take care.

That concludes Chris Labonte's interview with Thomas L. Johnson, executive director of Medicaid Health Plans of America. Information on Medicaid Health Plans of America, including their big annual conference this fall, is on the web at www.mhpa.org.

To learn more about Sellers Dorsey's work with states, health plans, and others on Medicaid managed care, please contact Chris Labonte, director of client services, at clabonte@sellersdorsey.com. Or visit us on the web at www.sellersdorsey.com.

On behalf of the Sellers Dorsey team, this has been Kip Piper. Thanks for listening.