

## **Medicaid HMOs Fight to Keep Pharmacy Services**

Arguing that they have the experience and can better maintain the continuity of health care needed by Medicaid recipients, managed care organizations (MCOs) that cover Pennsylvania's poor are fighting a move by the Rendell Administration to remove pharmaceutical care from their range of services. The Administration plans a January 2007 'carve-out' of the pharmacy services from the MCOs.

"The Medicaid managed care organizations have managed pharmacy services under HealthChoices [Pennsylvania's Medicaid managed care program] for nearly ten years," said Daniel J. Hilferty, President and CEO of Keystone Mercy Health Plan in Philadelphia, the largest MCO in the state. "We believe that a pharmacy carve-out will result in considerable confusion and frustration for health care providers and Medicaid recipients who will be forced to work with separate entities to resolve medical and pharmacy issues."

The planned move hits the MCOs at an especially difficult time. For the fiscal year that begins in July, Governor Rendell has proposed a four percent increase in the reimbursement rate for Medicaid services, which the MCOs argue may not be enough to maintain services.

"This would make it the third consecutive year that increases have failed to match the growth in health-care expenses," said Mike Blackwood, the Chief Executive Officer of Pittsburgh-based Gateway Health Plan. "Because medical costs are growing at about 8 percent or 9 percent, we project that Gateway would operate in the red next year if payments aren't increased."

## **Compromise on 'Joint and Several' Measure May Be in the Works**

Preliminary discussions between proponents of limiting 'joint and several' application in liability cases and the Governor's Office have begun in an effort to find some middle ground on legislation he vetoed earlier this year. Sources contacted said the early talks are centering on a key provision in the legislation concerning a percentage threshold for when joint and several would kick in where there are multiple parties in an injury suit. They also indicated it's too early to say what success, if any, they might have.

"I want to caution that this is very early, but we feel there is enough going on politically that the Governor will be more receptive to signing it," one business lobbyist said.

Governor Rendell faced criticism from the business community, and is still facing some heat in the press, over his veto of a joint and several measure, SB 435, that by all accounts was identical to language he supported in his initial run for Governor in 2002.

In his veto message, the Governor Rendell said that the joint and several legislation balanced the scales in favor of the defendant. The legislation made a defendant proportionally responsible for damages if his level of fault in the case were deemed to be less than 60 percent. If more than 60 percent, then a defendant could be responsible for all damages.

An amendment favored by the Governor, that narrowly missed being attached in the House and Senate, would have made a defendant proportionally responsible for damages only if he were deemed less culpable for the injury than the plaintiff. Otherwise, full joint and several would hold.

The amendment would also hold that where there is a defendant who is unable to satisfy his proportionate share of the liability, his share shall be allocated among all the remaining parties. However, the share that is reallocated among the remaining defendants is first reduced by the proportionate share of the plaintiff's comparative negligence. Finally, any defendant who pays more than his proportionate share of damages is statutorily authorized to seek contribution from other defendants found liable in an amount equal to their proportionate share of responsibility.

That language, however, is a non-starter for the business community.

"It's not a compromise. It's not reform," one business leader said.

Rather, business leaders may bend on the 60 percent threshold provision – perhaps, a move to 50 percent before joint and several would apply might be a compromise point.

"We feel there might be a political opening so now is the time to jump on it," the business leader said.

## **Greater Use Of Medicaid HMOs Would Save State/Federal Government Billions, Study Says**

Expanding the use of HMOs in the Medicaid sector would save federal and state government, which share of the costs of Medicaid, billions over the next ten years. The study, by the Lewin Group, predicts the savings could go as high as \$83 billion.

The study was hailed by the Washington-based Medical Health Plans of America, which represents managed care plans serving Medicaid enrollees.

"We engaged Lewin to obtain an objective assessment of the potential for savings," noted Thomas Johnson, Executive Director of the Medicaid Health Plans of America, one of the study's co-sponsors. Margaret Murray, Executive Director of the Association for Community Affiliated Plans, also a co-funder of the study, added: "We were interested in quantifying the degree to which capitation is currently in use as well as the large-scale savings opportunity that still remains."

Some of the study's specific findings regarding the existing use of capitation are summarized below:

-- In the most recent year in which full national data are currently available, FY2003, 16% of national Medicaid expenditures were paid in the form of capitation.

-- Only one state, Arizona at 85%, "capitates" more than 50% of Medicaid spending. Five other states capitate more than 30% of Medicaid spending -- Pennsylvania (46%), Michigan (45%), New Mexico (44%), Oregon (39%), and Hawaii (36%).

-- Seven of the nation's ten largest Medicaid programs (FL, IL, MA, NC, NY, OH and TX) rank 25th or lower in the degree of their Medicaid spending that is capitated.

-- Within the blind and disabled Medicaid population, only 14% of Medicaid spending was paid via capitation in FY2003 (even after removing all spending on dual eligibles and long term care).

Joel Menges, a Vice President at Lewin and the study's principal author, noted that this disabled subgroup creates a particularly important financial and programmatic opportunity for states. "The characteristics of the non-Medicare SSI population are more amenable to the use of the capitated model than the TANF population. Capitation contracting has been least-used for the Medicaid subgroup where this coverage model seems best-suited to have beneficial impacts."

Nationally, Lewin estimates that \$67 billion of Medicaid fee-for-service spending as of FY2003 (29% of total expenditures) can be favorably impacted by expansion of the capitated model. Regarding the specific savings estimates, Lewin's key findings are that:

- At a national level, maximum savings of \$83 billion would occur across ten years if the capitation model were immediately applied to all the Medicaid funds that this model seems well-suited to impact. (These savings are entirely attributable to expansion of the capitated model and do not include the savings already occurring through existing Medicaid capitation programs.)

- Most of these savings (\$55 billion or 67% of the national total) would occur through transitioning the non-Medicare blind/disabled population into the capitated setting.

- 87% of the total savings would result from expanded use of the capitation model in urban areas; 13% of the total savings would be attributable to use of this model in rural areas.

- The state and federal share of savings is determined by the match rate in each state; maximum nationwide savings would be split 56% Federal and 44% state.

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