U.S. Senate Special Committee on Aging

Testimony of Daniel J. Hilferty

Good morning, Chairman Smith and Members of the Committee. I am Daniel J. Hilferty, President and CEO of AmeriHealth Mercy and Keystone Mercy Health Plans, based in Philadelphia, Pennsylvania. I also serve as Vice Chair of the Medicaid Health Plans of America (MHPA), a Washington, D.C-based trade association representing the Medicaid managed care industry. I am pleased that you have asked me to appear before you this morning, along with other key stakeholders, at this public roundtable on Medicaid managed care.

Chairman Smith, on behalf of AmeriHealth Mercy and MHPA, we want to commend you for your leadership in ensuring that Medicaid will be adequately funded. We thank your for your leadership efforts during this Congress and over the years, including the formation of the bipartisan commission to study the Medicaid program.

AmeriHealth Mercy and its affiliates comprise the largest family of Medicaid managed care plans in the United States, touching more than 2 million lives in 16 states. AmeriHealth Mercy is driven by its mission, to help people get care, stay well, and to build healthy communities. AmeriHealth Mercy has 23 years of experience serving the Medicaid population. We know this population very well. We have extensive experience with voluntary and mandatory Medicaid markets, with the Medicaid TANF and SSI populations, and we also serve CHIP populations in three states. We operate four Medicaid-specific product lines, full-risk managed care; management and administrative

services; PerformRx, a pharmacy benefit management program for Medicaid and Medicare Part D; and PerforMED, our care coordination program.

AmeriHealth Mercy has proven that managed care works for Medicaid in the marketplace. We have met and exceeded the states' goals of improving quality of care, increasing access to care, and saving money. We have accomplished this through innovative approaches to care management, collaborative provider relationships, community outreach, and efficiencies through enhanced technology. I would like to share with you some of our success stories.

Initially, our health plans took on full risk for the health care of mostly women and children in the TANF segment of the Medicaid population. In the late 1990s, states began mandatory enrollment of the Aged, Blind and Disabled populations into managed care programs. In Pennsylvania, adding this population caused our pharmacy costs per member per month to more than double in one year, and we saw an immediate spike in the utilization of health services. We realized that we needed to change our approach to care management, or the costs of caring for this population would put us out of business.

This is what we learned about caring for people with chronic illnesses: these members were getting a lot of care, but it was not always good care, or necessary care. We started a program of intense care coordination called PerforMED that predicts which members will be high care utilizers, and we found that about 20 percent of our members accounted for 80 percent of our costs. By identifying these members using predictive modeling, we

can intervene to prevent acute care episodes. We saved 26 million dollars from PerforMED the first year it was implemented by reducing the need for acute care such as ER visits and inpatient admissions for the 2,500 members enrolled in the program.

We also developed our own Medicaid-specific approach to pharmacy management, PerformRx, to address the increase in pharmacy costs. By integrating medical management and pharmacy management, we have been able to reduce our annual pharmacy cost trend from 18 percent to 25 percent to less than 5 percent.

Our experience with the Medicaid population has taught us that you need to be in the community to reach the members. Healthy Hoops is a great example of our community outreach programs**.** Healthy Hoops uses the sport of basketball to teach children with asthma and their families how to manage the disease through appropriate medication usage, proper nutrition, monitored exercise and recreational activities. After four years of the program, we are able to measure clinical improvements for Healthy Hoops participants. For example, the 2004 program reduced ER admissions by 63 percent, decreased rescue medication use by 13 percent and decreased sleep disturbances by 70 percent.

Medicaid health plans have not only increased access and quality, they have also delivered cost savings and held down the rate of cost escalation. The role of our industry has been well documented in the Commonwealth of Pennsylvania. A study undertaken by The Lewin Group shows that Medicaid managed care under Pennsylvania's

HealthChoices program has worked "remarkably well" for all stakeholders, and its financial performance makes it a "national model." Our industry has delivered "massive savings" to the state, as Lewin estimated that Pennsylvania received 2.7 billion dollars in savings over a five-year period. Another Lewin study commissioned by the MHPA determined that expanding managed care capitation to Medicaid nationally could achieve 83 billion dollars in savings over ten years. If Congress and the President would mandate Medicaid managed care, this would save the government far more than proposed currently, and in the process would improve care for Medicaid recipients.

Medicaid is at a crossroads. There are unprecedented opportunities for program re-design that could build on existing care improvements and cost savings. There is an opportunity to provide incentives for Medicaid recipients and families to live healthier lifestyles, emphasize prevention and primary care, and manage chronic illness.

Managed care works for Medicaid. It has increased access, improved quality and prevention, and saved billions in taxpayer dollars, despite having to work within the constraints of Medicaid regulations designed for the old fee-for-service model. Managed care has also afforded people on Medicaid the kind of health care that you and I take for granted – access to quality care from top doctors and hospitals, provided with dignity. The time is right to fulfill the potential of Medicaid managed care. Benefit re-design can make managed care more effective by putting incentives into place to promote prevention and healthy lifestyles and by identifying and coordinating care for members with complex health needs. The public/private partnerships already exist to enable this.

My colleagues and I stand ready to continue our work in improving the health of Medicaid recipients.

Thank you again for allowing me to appear before the Committee this morning.