Recent Testimony of Daniel J. Hilferty, President and Chief Executive Officer of Keystone Mercy and AmeriHealth Mercy Plans, before the House Health and Human Services Committee

I am Daniel J. Hilferty, President and Chief Executive Officer of Keystone Mercy and AmeriHealth Mercy Health Plans. I would like to thank you for the opportunity to speak today. I also want to commend Chairman Kenney and the Health and Human Services Committee for taking the lead in examining the HealthChoices model and the critical role that it plays in the Commonwealth's Medical Assistance Program.

HealthChoices has been a striking success for Pennsylvania. Managed care for Medicaid clearly works. The Lewin Study results confirm that HealthChoices achieved all of the Commonwealth's goals for the program. It has saved the Commonwealth significant Medical Assistance dollars, while improving access and quality of care for recipients.

HealthChoices also consistently shows high consumer satisfaction – both in formal surveys as well as personal anecdotes from consumers and advocates.

Medicaid spending and types of programs are gaining significant attention around the country as states look to reform their Medicaid programs in innovative ways. It's interesting to note that the States that are getting the most press right now-- Florida, South Carolina, Ohio – are all relying on managed care as the core of their reform efforts. Pennsylvania is far ahead of many other states with its well established and well run Medicaid managed care program, HealthChoices.

Over the past two days, others have spoken at length about the effectiveness of the HealthChoices program. So, I want to spend my time here with you today talking about the broader context –the rising costs of Medicaid for the Commonwealth of Pennsylvania.

Two Saturdays ago, I spoke with the Governor. He told me that the Commonwealth must find significant cost savings for Medicaid in the 2006-2007 budget. Secretary Richman echoed those words in a recent meeting with the Coalition of Medicaid Managed Care Organizations.

We understand that the Commonwealth remains in a difficult financial situation for the coming budget year. While revenues are growing, the State is also faced with further losses in Federal Medicaid funding. At the same time, caseloads continue to grow – partly fueled by the increasing number of elderly needing long term care; partly the result of low-income workers without Health Insurance from their employers. And, health care inflation continues to outpace other sectors of the economy, putting increasing pressure on the Medical Assistance budget.

Keystone Mercy, AmeriHealth Mercy, and the other managed care organizations view their relationship with the Commonwealth as a collaboration. We want to be part of the

solution to the Medicaid predicament that we are all facing. A cost-effective, adequately funded Medical Assistance budget is critical to both the State and the MCOs.

During the last budget cycle, Keystone Mercy and the other MCOs suggested a series of cost savings alternatives for the Legislature to consider. But, those suggestions came fairly late in the process since the Governor had already submitted his budget proposal. These savings and funding assessments could have solved the budget problem.

I would like to present some of those recommendations to you today – early in the 2006-2007 budget cycle – so that they can receive serious consideration.

Expand HealthChoices State-wide

Our first suggestion is to expand HealthChoices statewide. The Rendell administration has made clear this first suggestion is not an option. However it is important that we raise it, because of its significant savings potential. Estimated savings could be more than $100 million.

I have already talked about the success of HealthChoices in containing Medical Assistance costs. We appreciate DPW's efforts to apply a level of care management to the non-HealthChoices counties through AccessPlus. However, to achieve maximum cost savings through managed care, the Commonwealth must use the full-risk model as documented by the Lewin Study. Full-risk capitation is essential to controlling and predicting costs for any state trying to control costs – and Pennsylvania has the gold standard. Expanding HealthChoices statewide would have both an immediate and a long-term impact on containing Medicaid costs in the Commonwealth.

Adopt Medicare's Approach to Nonparticipating Providers

There are also cost savings that could result from improving the current HealthChoices design. One way to achieve greater cost savings is for the State to adopt a provision regarding provider payments that mirrors Medicare's. Medicare does not allow its managed care contractors to pay non-participating providers more than Medicare Fee for Service.

Here in Pennsylvania, the HealthChoices MCOs have traditionally contracted at rates that are higher than Medicaid Fee for Service for hospitals, physicians and other providers. We did this to improve access for Medical Assistance recipients, and we made it work by offsetting higher provider costs with savings from managing and coordinating medical care, and emphasizing preventive care. And by the way, that's the bottom-line benefit of managed care – actions that promote cost savings can also result in better health outcomes.

However, sometimes providers demand excessive rates as a condition of continuing in our network. Our alternative is to drop them from the network, where they charge even higher rates when they see one of our members on a non-par basis. Adopting language similar to Medicare's would level the playing field in contract negotiations. Potential savings could reach into the millions of dollars.

Align Incentives for Primary/Preventive Care

Another tool to improve HealthChoices is to better align incentives to encourage effective primary and preventive care. Not only does this help consumers maintain better health status, it helps avoid more costly care. For example, we support restructuring co-pays so that there would be higher co-pays for the non-emergency use of emergency rooms and minimal or no co-pays for visits to the doctor.

Keep Pharmacy with the MCOs

Keeping pharmacy management with the MCOs will continue to produce significant savings for the State. The current budget anticipated moving the MCOs under a Medicaid-wide Preferred Drug List with rebate collections going directly to DPW. There have been a series of issues that, to date, have prevented implementation of that plan – ranging from difficulty in obtaining Federal approval to lack of participation by key pharmaceutical manufacturers. We believe that this is actually a positive outcome from both the MCOs' and the State's perspective. The Preferred Drug List is one of those concepts that sound good as an idea, but suffers in the execution.

The MCOs have had many years of experience in successfully managing pharmacy costs. The Preferred Drug List proposal would force the MCOs to adopt DPW's less comprehensive and less tested approach to utilization management. The PDL also disregards the complex relationship among multiple factors, including a clinically effective formulary design, rebate management, and drug pricing. It is this balance that allows the MCOs to achieve substantial pharmacy savings for the Commonwealth. Keystone Mercy has been so successful, in fact, that Medicaid health plans across the country have contracted with us to manage their pharmacy services. Keeping pharmacy with the MCOs is the most cost-effective approach for the Commonwealth.

Place Excise Tax on Smokeless Tobacco

We recommend that Pennsylvania join the forty-nine other states that have placed an excise tax on smokeless tobacco products. Chronic conditions associated with smoking and smokeless tobacco cost the Medical Assistance program millions of dollars each year. Research has shown a direct correlation between taxing these products and a reduction in consumption among adolescents and young adults. Implementing such a tax can potentially save the Commonwealth millions of dollars in tobacco-related illnesses and generate tens of millions of dollars in new revenue that could be used to support the Medical Assistance Program. Potential savings could be $40 million.

Dedicate PACE Dollars to Medical Assistance Programs

Medicare Part D will free up significant dollars from the PACE program as seniors receive a greater portion of their pharmacy coverage through Medicare. We recommend that these PACE dollars be dedicated to Medical Assistance programs that serve senior citizens, such as the home and community based programs and other long-term care programs. This change would also allow the lottery funds to be matched by federal funds.

In Closing

The Pennsylvania Medical Assistance Program is at an important crossroads. The program provides critical services to nearly two million citizens. It is a safety net that, as a society, is our obligation to provide. However, we need a program structure that can be sustained by Commonwealth revenues without affecting other equally important public programs.

The challenges are huge – but we already have a key part of the solution in place. Pennsylvania has a proven national model for controlling Medicaid costs and improving health outcomes. The HealthChoices Program is rational policy regardless of your political party or philosophy. HealthChoices embodies public responsibility and private energy – the Commonwealth has constructed a framework in which innovative Managed Care Organizations deliver quality care to recipients with guaranteed savings to Pennsylvania taxpayers.

We believe that making a re-commitment to the HealthChoices program and adopting the other suggestions that we have presented can result in a viable Medical Assistance Program that does not unduly burden the Commonwealth's taxpayers. Medicaid managed care works; let's make it work harder for Pennsylvania.

Testimony of Sherry Knowlton, Senior Vice President and General Manager AmeriHealth Mercy Health Plan, before the House Health and Human Services Committee

My name is Sherry Knowlton. I am Senior Vice President and General Manager of AmeriHealth Mercy Health Plan. AmeriHealth Mercy manages the delivery of health care services to over 86,000 Medicaid consumers in 15 counties in central and Northeast Pennsylvania.

Thank you for the opportunity to testify today. I applaud Chairman Kenney and the Committee for your interest in seeking input on Medicaid Managed Care and the important issues facing the State's Medicaid program. My testimony today will focus on two major topics, the value of Medicaid Managed Care in Pennsylvania, and the need to put issues relating to Medicaid in a broader context.

HealthChoices has been Pennsylvania's primary Medicaid Managed Care model for nearly a decade. The original intent of HealthChoices was to increase access, improve quality of care, and control the rate

of growth of Medicaid expenditures. I believe the Commonwealth should take great pride in the fact that the program has achieved all three of its goals.

The HealthChoices Program and the State's commitment to managed care for Medicaid truly has been a bi-partisan effort. Medicaid Managed Care began in Pennsylvania in the early 70's – one of the nation's pioneering experiments. HealthChoices itself was designed during the Casey administration, then implemented and expanded by the Ridge and Schweiker administrations. HealthChoices has become a national model that other states look to when improving their Medicaid delivery systems.

The Lewin Group will testify in this hearing about their study that confirms the significant cost savings and quality and access improvements that the State has gained as a result of HealthChoices. There are two other recent studies that reach similar conclusions. The Rockefeller Commission study validated Pennsylvania's approach to managed care and complimented the Department of Public Welfare (DPW) for its comprehensive monitoring of Managed Care Organizations (MCOs). A study commissioned by Michigan's state legislature and conducted by the Center for Health Programs found nearly identical results to the Lewin Study in terms of cost effectiveness – that both Medicaid Fee for Service (FFS) and Primary Care Case Management (PCCM) are more expensive than capitated full risk managed care (the HealthChoices model).

It is important that State government revisit broad public policy issues on periodic basis. Assessing the effectiveness of HealthChoices is timely, especially in light of the growing pressures to fund Medicaid. One of the primary reasons for originally adopting HealthChoices was to save money. I believe that, a decade later, the fact that HealthChoices still achieves those savings is less visible because the continued lower cost trend of MCO managed care is now embedded in the Medicaid budget. However, lower visibility does not make those cost savings any less real.

A question for the Committee to consider is: What would happen if HealthChoices was dissolved and we went back to FFS or a PCCM model like AccessPlus? I believe the results would be extremely negative.

- **Costs would rise dramatically** as the Medicaid program returns to one that has little control over utilization. Before HealthChoices there were two extremes. On one hand, there were recipients who overused specialty care providers. Without the utilization management and case management interventions of the MCOs, Medicaid could easily return to the member and provider driven system that it was in the early 90's.

- On the other hand, there would be **many consumers with reduced access to care**. Prior to HealthChoices, many members had little access to primary or specialty care, so they used the Emergency Room for routine care or were hospitalized when untreated medical problems became serious. The HealthChoices plans must guarantee access to their members. We have achieved this partly by enrolling providers who never participated in Medicaid FFS in our networks. These providers will not stay in a FFS/PCCM environment. So, the result will be higher costs as members use expensive Emergency Room or inpatient hospital care.

- Ending HealthChoices would also create **increased pressure from providers for higher Medicaid payment rates**. Today, a significant portion of the State's hospital, physician and other providers receive most of their payments for Medicaid services from managed care plans. And, the MCOs generally reimburse providers more than FFS. MCOs offset these higher payments by coordinating care, placing strong emphasis on preventive health care, providing disease management for chronically ill patients, and offering innovative programs to promote the health of our members. Without HealthChoices, providers would come directly to the Administration and the Legislature for higher Medicaid rates.

- Another fall-out from ending Health Choices would be **a reduction in quality of care**. There are few quality measures in Medicaid FFS. While there are some quality aspects built into AccessPlus, the standards are not as comprehensive as those for HealthChoices. AmeriHealth Mercy is committed to ensuring that our members have access to high quality, integrated, patient-centered health coverage. *US News and World Report* recently ranked AmeriHealth Mercy and all of the HealthChoices MCOs in the nation's Top 25 Medicaid Managed Care Plans based on quality of service.

- There would be **a negative impact on Pennsylvania's economy** if HealthChoices would end. The MCOs are an integral part of that economy. We employ Pennsylvania citizens. Most of our premium dollars go to hospitals and other providers, who in turn employ others in the community. We help maintain a robust safety net for many people returning to the workforce Healthcare is the fastest growing segment in Pennsylvania's economy. The MCOs are a significant part of the mix.

Can HealthChoices be improved? Certainly, we should all be looking for ways to further refine the program. AmeriHealth Mercy is willing to participate in those discussions and has specific ideas on ways to improve the program. But, the broad public policy question should not be – does HealthChoices save money or should HealthChoices continue? The question should be:

> **Since HealthChoices saves the Commonwealth significant dollars, how quickly can we expand it into the rest of the State?**

Expanding HealthChoices would save real dollars as well as increase federal matching monies that the State receives from the MCO assessment. A few years ago, MCOs were poised to expand into the Northeast and the Northwest. Reviving those HealthChoices procurements could be done in the next fiscal year if DPW acted quickly.

Turning briefly to another subject. I ask this Committee to look at the broader picture as it considers both HealthChoices and the Medicaid program. Healthcare costs in all sectors continue to climb at a higher rate than inflation due, among other things, to advancements in medicine, especially in end of life care, neonatal care, and the rising cost of new pharmaceuticals. And, as you look at what is often referred to as the "problem with Medicaid", remember that Medicaid is the safety net that catches many of those people who otherwise would fall through the rapidly widening cracks in our nation's healthcare system.

The rising Medicaid caseloads in our State are being driven primarily by the growing number of elderly receiving long term care services as well as the large number of working poor who now qualify for coverage. Medicaid these days is not a program

that just provides coverage to people on cash assistance. The old stereotype of the Medicaid recipient is an unemployed mother and her kids. Today, Medicaid casts a much wider safety net. Today, most of us don't have to look too far afield to the answer the question: Who do I know who is on Medicaid? For me, it is:

- Diane, one of my son's young friends who works at a day care center that provides health insurance. However, she doesn't make enough money to pay for her living expenses plus the insurance premium.
- Before he died an early death from his Down's syndrome, much of my brother-in-law Bobby's care was funded by Medicaid.
- My grandmother turned to Medicaid when she depleted all of her assets after three years in a nursing home.

I suspect that all of you could think of similar people in your life who rely on Medicaid for their health care coverage.

Pennsylvania has historically been in the forefront of programs that provide health care to low-income uninsured citizens. Expansions in Medicaid eligibility beyond the Federal minimum, state-funded General Assistance, and other programs such as PACE all demonstrate the Commonwealth's commitment to its most vulnerable. Perhaps, it is time for the State to reexamine not just HealthChoices and not just Medicaid, but all of its publicly funded healthcare programs to determine if there is a more effective way to structure the programs and draw down more Federal funds. In addition, Pennsylvania may want to look at what other states are doing to lessen the burden on State funded health coverage such as defined employer contributions, purchasing pools and other ways to make it easier for small business to provide health insurance for their employees.

It is important that the Commonwealth preserve the broad safety net that Medicaid and its other low-income healthcare programs offer. However, rising costs of Medicaid cannot be addressed without considering the broader context of healthcare in the State.

As you consider the next steps for Medicaid in Pennsylvania, it should be clear that HealthChoices is a key component in the future of the program. HealthChoices, by itself, cannot solve all of the problems that we face today in Medicaid. But, continuing HealthChoices in the three zones in which it currently operates is critical to containing Medicaid costs. And, expanding HealthChoices to the other counties across the State should become a priority to obtain additional savings for the Medicaid program. HealthChoice's original goals of increased access, improved quality of care, and cost containment are just as relevant today as they were a decade ago.