

MANAGED HEALTHCARE EXECUTIVE™

JANUARY 2003

Small teams, **big** returns

AmeriHealth Mercy
CEO Daniel J. Hilferty
moves forward
with selective
partnerships

©Reprinted from
MANAGED HEALTHCARE EXECUTIVE
January 2003
AN ADVANSTAR PUBLICATION
Printed in U.S.A.

Copyright Notice Copyright by Advanstar Communications Inc. Advanstar Communications Inc. retains all rights to this article. This article may only be viewed or printed (1) for personal use. User may not actively save any text or graphics/photos to local hard drives or duplicate this article in whole or in part, in any medium. Advanstar Communications Inc. home page is located at <http://www.advanstar.com>.



Small teams, big returns

AS A FORMER COLLEGE ATHLETE, Daniel J. Hilferty, president and chief executive officer of AmeriHealth Mercy/Keystone Mercy in Philadelphia, knows how critical teamwork is. Teammates are especially helpful when dealing with complicated healthcare issues, such as serving the Medicaid population.

Since he became CEO in 1996, Hilferty has used a team approach to guide AmeriHealth Mercy and its affiliated plans to become one of the largest families of Medicaid managed care plans in the United States, with more than a million members in five states.

While the team approach might be the way to go, it doesn't mean collaborating with everyone in sight. Instead of growing larger, Hilferty predicts managed care plans will become more focused on a smaller network of providers and related services.

"What I think you'll see in

the future is MCOs shrinking their networks and relying only on groups of providers whom they feel are solid and mature enough, from a medical management perspective, to work with," he says from the company's headquarters in Philadelphia. "The search will be on to locate those physicians who are high-quality and put the patient first."

But even getting to that point requires collaboration, he says. AmeriHealth Mercy's expertise is in serving populations most in need of assistance. Care of the poor and disadvantaged is at the core of company's mission. AmeriHealth Mercy Health Plan

was formed in 1996 as a partnership of Independence Blue Cross and Mercy Health System. This unique partnership of a provider system and an insurer works because Independence Blue Cross and Mercy Health System have overlapping missions.

Independence Blue Cross has a history of being the insurer of last resort, and Mercy is

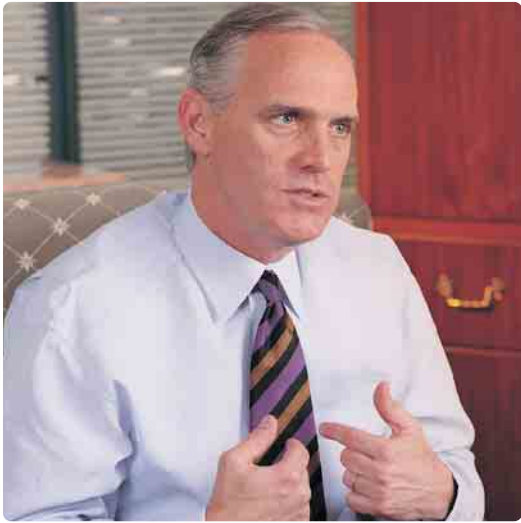
AmeriHealth Mercy CEO Daniel J. Hilferty moves forward with selective partnerships

story | **Michael T. McCue**

photographs | **Bob Coldwell**

DANIEL J. HILFERTY

Small teams, **big** returns



committed to meeting the healthcare needs of vulnerable, needy populations. This synergy led to their partnership, and while their respective areas of specialization are different, they are highly complementary.

Getting on the same page

By identifying high-quality providers and developing a closer relationship with them, plans will be able to loosen the restric-

tions that frustrate so many members and providers alike. Plans will know that the doctors in their networks understand and agree with their medical management criteria, so there won't be a need to monitor their actions as closely—only to work toward agreed-upon quality standards.

“For example,” Hilferty says, “there are three Medicaid managed care entities here [in the Philadelphia region] that serve a five-county area. We might have a good relationship with one group of providers, while the other plans have their own particular group of providers.

“In the areas where we do not have the best relationships with physicians, we might need only a basic contract for emergency room services. The idea is to build a place where our members can go to get the full range of services. Of course we will need to have some presence in the other areas, but our business plan will be geared toward having a contract for a full range of services with our preferred providers, who best know our needs, and a basic contract with non-preferred providers.

“The other plans will probably build networks in other areas, where they have the best relationships. The bottom line is that we're going to be more focused. They'll niche, and we'll niche.”

Because Mercy's Partnership Board is in tune with the needs of the population served by AmeriHealth Mercy/Keystone Mercy, the management team has been able to serve its members with creativity and zeal.

“G. Fred DiBona, chairman of the board for AmeriHealth Mercy/Keystone Mercy and president of Independence Blue Cross, has a deep understanding of the healthcare system and the needs and interests of providers and consumers/members, and a particular understanding of disadvantaged members. Fred has been a mentor to me for the past six years,” Hilferty says.

“With our partners at Independence Blue Cross and Mercy Health System, we know we have full support to supply access to quality care for our members. It's the combination of perspectives among the partners and the management team that lets us find innovative and collaborative ways to meet the needs of everyone involved.

“No one, and I mean no one, can do it on his own. The key is to find people whose goals and vision are similar to yours, but whose backgrounds are in different areas. It's the only way to grow and learn how to do your own job better.”

“The bottom line is that we're going to be more focused. They'll niche, and we'll niche.”

AT A GLANCE



HEADQUARTERS

100 Stevens Drive
Philadelphia, PA 19113

FOUNDED

1982

MODEL/PRODUCTS OFFERED

Medicaid Managed Care/State Children's Health Insurance Plan (SCHIP)

MARKETS SERVED

The State of New Jersey and portions of Kentucky, Missouri, Pennsylvania and South Carolina. Affiliates include AmeriHealth Mercy Health Plan, Keystone Mercy Health Plan, Care

Partners, Gateway Health Plan, Horizon Mercy, Select Health, Passport

ENROLLMENT More than 1 million

STAFF 1,600

FINANCIALS Combined annual revenue of \$2 billion (AmeriHealth Mercy & Keystone Mercy)

ACCREDITATION AmeriHealth Mercy Health and Keystone Mercy Health Plan have Excellent accreditation from NCQA

AWARDS 2002 Corporate Partnership Award from Youth Leadership Foundation; 2001 Pennsylvania Governor's Achievement Award for innovative Welfare to Work program

“The states have to be serious about what they are going to cover and what they aren’t.”

Back to the basics

In spite of the often-adversarial positions of plans, providers and payers, none of them want people to go without medical care. But in light of the growing number of uninsured, most recently cited at about 41.2 million Americans, the debate has shifted to the way benefits are distributed. That’s a top-of-mind issue for Hilferty, who knows that there is much more demand than the current supply can handle.

Hilferty has a specific solution for expanding the benefits package for the un- and underinsured, and it involves several basic strategies. The first relies on the government to define exactly what the “basic healthcare benefits” package is, and sticking with it.

“The states have to be serious about what they are going to cover and what they aren’t,” he says. “They have to be able to say, ‘We’re going to do this much, but that’s it. Because of our financial restraints, this is the limit that we can provide.’ That’s the only way to minimize the costs of basic healthcare and get some level of coverage to the millions who have none.”

“The Medicaid population typically accesses health-care in two

places: local public clinics and emergency rooms. We help people on Medicaid get an insurance card and have them assigned to a primary care physician. Entities like us can do more than schedule appointments; we can help them with issues such as transportation. So instead of people being unhappy with their healthcare situation, we can introduce a certain amount of dignity and increased access for people who belong to Medicaid managed care programs.”

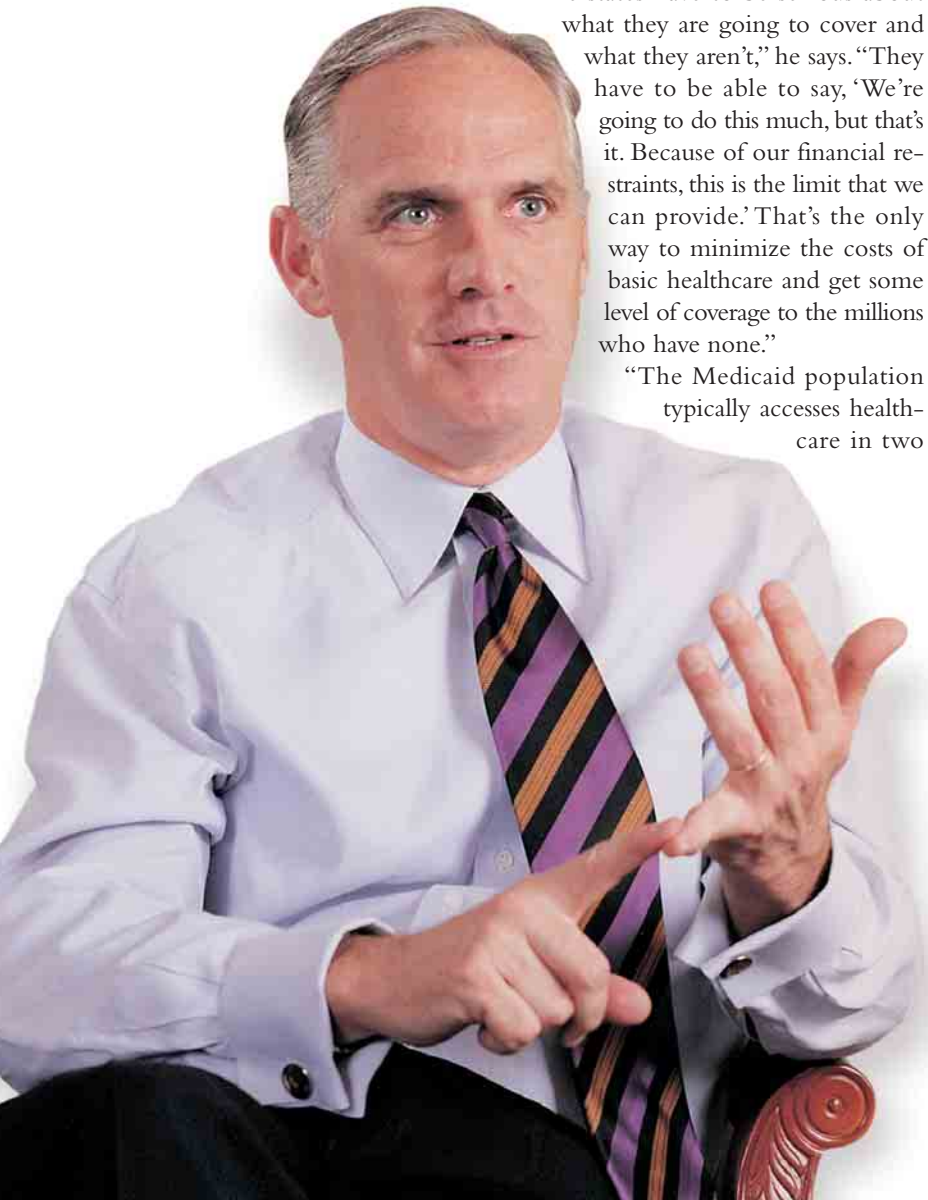
The next step involves risk pools and case managers for people with chronic diseases, those with very serious diseases, such as AIDS, and those with rare conditions, such as hemophiliacs with allergies to traditional Factor VIII medication.

Another strategy that Hilferty and his executive team have implemented is insourcing their prescription benefit plan. It’s not a strategy that every plan can implement, because it requires extensive expertise and a certain number of members to achieve the critical mass necessary to make it work. But because of its size and market share (more than 50% in the Philadelphia region for example), AmeriHealth Mercy/Keystone Mercy is making it work.

“This was one way we felt we could improve our services to members and providers while gaining greater control over our drug cost trend,” he says. “It has given us a direct line to the pharmaceutical manufacturers, that, as a whole, need to work collaboratively with managed care entities to improve quality while minimizing costs.”

The company’s drug cost trend reached a critical point in the late 1990s, topping 19%. It was cut to about 8% in 2002, a savings of millions. “There’s a place for PBMs, but this is something we thought we could do on our own,” he says. “Due to the program’s success, we are now marketing the concept to other Medicaid managed care plans and State Medicaid programs.”

The results of that strategy are impressive. In 1999, Keystone Mercy had about 60 hemophiliacs whose care cost about \$10 million annually. Through careful case management and negotiating with manufacturers for the best unit-cost on drugs, the company shaved more than \$2 million off its costs, even



though the number of hemophiliacs in its membership has increased.

Minimize costs, minimize awards

Meanwhile, healthcare is seeing its coffers bled dry by another insurance industry: malpractice. For years, there's been no small amount of ill will between health plans and physicians. But both sides (and thus patients as well) are terribly alarmed by developments in the nation's courtrooms, so it's a case of "the enemy of my enemy is my friend." The American Association of Health Plans and the American Medical Association have both targeted litigation as one of the industry's greatest threats.

According to Hilferty, health plans' ability to further minimize costs depends on eliminating the super-sized awards given to plaintiffs in malpractice lawsuits.

"This is a direct culprit when physicians talk about their declining reimbursement and income," Hilferty says. "A lot of people think that just means physicians are getting paid less by the government and health plans, but that's not necessarily the case. Their take-home pay is being drastically reduced because malpractice insurance is skyrocketing."

A lot has been written about geographic variation in the way physicians practice medicine (next month's Executive Profile is on Dr. John E. Wennberg of Dartmouth's Center for the Evaluative Clinical Sciences), and it's acknowledged that the lack of consistency is a driver of costs and a hindrance to quality care. But the awards given to plaintiffs in malpractice claims vary as well, with perhaps no smaller a negative impact on healthcare.

"In 2001, the amount of money awarded to successful plaintiffs in malpractice suits in the city of Philadelphia was higher than the amount awarded to successful plaintiffs in the entire state of California," Hilferty says. "This is the kind of thing that drives physicians out of Pennsylvania, or out of the profession altogether."

In 1975, California's governor and state legislature passed the Medical Injury Compensation Reform Act, which limited attorneys' fees and placed a \$250,000 ceiling on damage awards for pain and suffering. The average mal-

A CLOSER LOOK

State programs suit this CEO

HEALTHCARE wasn't Daniel J. Hilferty's first love, just his current one. His initial interests were government and public policy. After graduating from college, he delayed going to graduate school to work as a volunteer, running a community center in Portland, Ore., for more than a year.

"After I graduated, I joined an organization similar to the Peace Corps," he said during an interview in AmeriHealth Mercy/Keystone Mercy's Philadelphia headquarters. "When you're running an organization that relies heavily on donations and public funding, you learn a lot about how government works."

Those first two interests—community service and public policy—are what ultimately led Hilferty to a healthcare position in community and government affairs with Mercy Health System in Philadelphia, and then to his current role as president and CEO of one of the nation's largest Medicaid managed care organizations.

"I arrived at my current position through a natural progression of varied experiences that have mattered to me," he says. "The people we help are the ones who need healthcare coverage the most, so it's definitely a

form of community service. And because it's Medicaid, I am dealing with governors, state legislatures and other politicians on a daily basis. To



top it all off, I get to run a pretty-good-sized company. I feel like I'm one of the luckiest people around."

Multiple perspectives, a single goal.

An avid basketball fan and former college player, Hilferty knows the importance of teamwork.

AmeriHealth Mercy/Keystone Mercy is a 50/50 joint partnership with Independence Blue Cross and Mercy Health System. Hilferty considers Independence Blue Cross president, G. Fred DiBona, Jr. a mentor: "Fred is, in my mind, one of the most creative and visionary leaders in the healthcare industry today. I have the benefit of learning from him on an almost daily basis.

"There are six members on our board of directors, three from Mercy Health System and three from Independence Blue Cross," Hilferty says. "Healthcare requires so many different perspectives and fields of expertise; the needs of this job surpassed my own personal skill set a long time ago. No one can do this himself. It called for surrounding myself with highly qualified executives with varied industry experience and expertise."

— Michael T. McCue

practice premium paid by California doctors used to be among the highest in the country; now it's in the lower third.

"If a user of healthcare gets poor service, a provider makes a mistake, or a plan denies care that it should allow, I certainly agree that there must be some level of action a member can take," Hilferty says. "But the way the system works now in most states benefits no one but trial lawyers." **MHE**