Testimony to the Alaskan Senate Subcommittee on Medicaid Reform

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Good morning Senators and thank for you inviting me to present this testimony regarding Alaska Medicaid reform. I am a primary care physician practicing emergency medicine in rural Minnesota. I am also Clinical Associate Professor in the College of Public Health at the University of Iowa. For your reference, my resume is attached. My research focus is healthcare reform, including shared savings plans (accountable care organizations) and telehealth. My rural healthcare policy group (RUPRI Health Panel) is currently preparing a report on Medicaid reform. Despite living in Minnesota, I have a great affinity for Alaska! I served as a medical student in Bethel (early 1980s), presented at ASHNHA meetings, and evaluated the Alaska Frontier Extended Stay Clinic (FESC) Program.

I recommend that the State of Alaska implement Medicaid shared savings plans, such as accountable care organizations or coordinated care organizations, that engage healthcare providers to improve care and maintain access within a fixed global budget. My recommendation is an addition to the important short-term Medicaid reform options discussed by the Menges Group.

The Alaska State budget challenge presents an opportunity to "bend the cost curve" of Medicaid expenses. Bold, but thoughtful, initiatives are needed that focus on the following priorities:

1. Concurrently improve patient care, advance community health, and use State resources wisely
2. Manage the Alaska State budget, in part via the Medicaid program
3. Engage healthcare providers, and thus the Alaska workforce, to encourage business growth

Alaska is different than the rest of the nation. Alaska Medicaid beneficiaries, and their healthcare providers, are widely dispersed geographically. But healthcare reform lessons from frontier areas in the lower 48 can be applied to Alaska. For example, the Eastern Oregon Coordinated Care Organization (CCO) operates in the geographic eastern three quarters of Oregon, an area with only 3.86 persons per square mile (in comparison, the Kenai Peninsula Borough has essentially the same population density at 3.40 persons per square mile).[1] Medicare, Medicaid, and commercial shared savings plans (ACOs) are rapidly expanding. ACOs operate in every state except Alaska, including many rural areas.[2] ACOs represent the cornerstone of healthcare reform because they engage healthcare providers, mandate quality improvement, and then share savings with those that actually provide health care. These reform programs are still in their infancy, yet early results are encouraging; the Oregon CCO program reduced inpatient spending by 14.8% and outpatient spending by 2.4% from 2011 to 2014.[3] The Medicare Shared Savings Program (Medicare ACOs) continues to expand and improve, indicating CMS' commitment to move away from fee-for-service payment to a new payment system that recognizes and rewards healthcare value (higher quality at lower cost).[4]

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[1] United States Census Bureau, http://quickfacts.census.gov/ and Eastern Oregon Coordinated Care Organization, www.eocco.com/, both accessed February 9, 2016.
[2] RUPRI Center for Rural Health Policy and Analysis, 2016.
[3] McConnell, KJ. Oregon's Medicaid Coordinated Care Organizations. *JAMA*. Published online February 4, 2016.
[4] Burwell, S. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. *New Engl J Med*. 372:897-899. March 15, 2015.

Although the Medicare Shared Savings Program is an impressive healthcare reform alternative, Oregon's CCO model may be more applicable for Alaska Medicaid. A CCO is a formal collaboration of healthcare providers and an insurer that accepts healthcare financial risk; that is, the State gives the CCO a single, comprehensive budget to provide most Medicaid services (inpatient, outpatient, emergency, behavioral health, etc.). In the future, dental, transportation, and even long-term care could be included. In exchange for the CCO's global payment, healthcare experts and the State establish strict quality of care and access standards. The CCO is thus incented to prevent beneficiary disease and disability (and consequently improve community health) by providing proactive preventive care, offering chronic disease management, managing the care of complex patients, establishing patient-centered medical homes, integrating behavioral health care, and engaging health-related community resources.

The ACO and CCO models represent critical improvements in healthcare financing. ACOs/CCOs encourage healthcare providers to "do the right thing;" that is, improve quality and lower cost, not just see more clinic patients or fill more hospital beds. It's the reason why I, and many of my physician colleagues, chose the great profession of medicine. But a perverse fee-for-service incentive system has always run counter to what we intuitively know is right. In contrast, ACOs/CCOs help providers actively participate in the laudable goals of better care, improved community health, and smarter spending.

ACOs/CCOs have another unique characteristic. Unlike managed care organizations (MCOs) that may focus on aggressive contracting and utilization control, ACOs/CCOs dynamically engage the most important healthcare stakeholders – providers who deliver the care and patients who receive the care – in making health care better and less expensive. Reliance on MCOs may be problematic in Alaska due to low population density and the risk that few MCOs would participate, thus limiting competition. More importantly, aggressive contracting may alienate providers, increase Medicaid non-participation, and jeopardize access to health care.

Although Oregon aggressively established CCOs without demonstration testing, other states are experimenting with ACO-type options. For example, my state of Minnesota is using a State Innovation Model (SIM) grant to establish Accountable Communities for Health using a multi-payer approach.[5] Alabama will create 11 regional care organizations that will "manage patients' cases to promote health and prevent expensive treatments,"[6] and then share savings with providers. Alaska may wish to test new ACO/CCO models of healthcare financing and delivery as demonstrations.

Thank you for this opportunity to discuss Alaska Medicaid reform. I believe that ACOs/CCOs offer the State of Alaska a creative and enterprising Medicaid reform path that engages providers to improve care and maintain access within a fixed global budget. I am sorry that I could not meet with you in person today, but please feel free to contact me. I'm as close as an email.

[5] Health Reform Minnesota. http://www.dhs.state.mn.us/ accessed February 10, 2016.
[6] Feds give Alabama go-ahead for Medicaid changes. *Montgomery Adviser*. February 9, 2016.