Mr. Chairman, members of the committee, thank you for the opportunity to testify today. For the record, my name is Rick Davis and I am the Chief Executive Officer at Central Peninsula Hospital in Soldotna. Central Peninsula Hospital is a 49 bed acute care hospital that is owned by the Kenai Peninsula Borough and leased to CPGH, Inc., a local nonprofit Corporation.

I was asked to provide testimony today to the House Finance Committee regarding Managed Care and Accountable Care Organizations as they pertain to SB 74, Medicaid Reform.

The Centers for Medicare and Medicaid Services defines ACO's as groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of this coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

The CMS definition I just provided speaks directly to Medicare, however my discussion about ACO's today will refer to specifically Medicaid. In this context, I am talking about an Accountable Care-like structure that I will refer to as a Coordinated Care Organization, or CCO. The key to the effectiveness of both the ACO and the CCO models is that both of these relationship structures take the majority of the risk away from the payer, and place it directly on the providers. These relationships make the provider responsible for maintaining low cost and high quality, or the provider suffers the consequences – not the payer. Which makes a lot of sense because the provider and the patient are the only two entities who really have the ability to affect health outcomes.

A Managed Care Organization differs from and ACO or CCO in that MCO plans are a type of health insurance. MCOs have contracts with health care providers and medical facilities to provide care for members at reduced costs in return for steerage of patients to those providers. The obvious difference between Managed Care

Organizations and Accountable or Coordinated Care Organizations is that – in the MCO model – the payer is taking on the risk both in terms of quality and cost. Instead of as I mentioned earlier, the providers taking that risk in the ACO/CCO model.

Now I'd like to give you some background about why and how CPH became interested in a variant of an ACO and our desire to pilot a demonstration project on the Kenai Peninsula.

Because we are a single stand-alone community hospital and are not part of a system or affiliated with a larger hospital, CPH must be diligent when considering future financial risk. We are keenly aware of the changing health care landscape and believe that a major transformation is beginning to take place. The changes I am referring to will cause reimbursements for health care services to be directly tied to quality, outcomes, and efficiency. This type of payment transformation is moving health care away from volume and towards value.

We have already begun to see these changes take place under Medicare with Value Based Purchasing and bundled payments. Because of this, we have elected to be proactive and prepare for anticipated changes in an effort to lessen the impact of shrinking reimbursements going forward. Nearly two years ago, we began to explore different options and payment models in order to better prepare for the compression on reimbursement as it begins to show up in Alaska.

We are interested in piloting an ACO variant that is based on an existing Community Care Organization or CCO that is operating in Eastern Oregon. Data released in February in the Journal of American Medical Association indicates that: Compared with a 2011 baseline, the Oregon Health Authority reported that per-member per-month spending for inpatient care had decreased in 2014 by 14.8%. Per-member per-month spending on outpatient care was also lower, by 2.4%. However, outpatient spending trends masked a 19.2% increase in spending on primary care services because care transitioned away from high cost specialty care, and over to the Primary Care Medical Homes

that are part of the CCO. This improved coordination of care – lead by the primary care provider is the key to lowering costs and improving care.

We would anticipate this model covering the entire Medicaid population on the Kenai Peninsula. CCO's differ from ACO's in their acceptance of full financial risk in the form of the global budget. They are similar in that they are both locally governed; are accountable for access, quality and health spending; and both emphasize primary care medical homes. Both require Robust Data Systems to support a Clinically Integrated network for clinical and business functions in addition to permitting the flow of data required to make informed decisions.

The CCO would operate on a fixed global budget, reduce medical cost inflation as part of the contract, improve the quality of care and outcomes and create a healthier population. The current Alaska trend of growth per capita for Medicaid expenditures averages just over 6%

per year and we believe this demonstration could help put Medicaid on a predictable and sustainable path by reducing the growth trend in per capita Medicaid expenditures.

We view the CCO as the next step beyond traditional managed care. This belief is simply based on the funding structure and risk bearing nature of the program. More importantly, providers will no longer be paid for treating illness but instead for providing a highly coordinated system that prevents illness and the high costs associated with it.

The CCO structure requires a great deal of front-end work to bring the stakeholders together and agree on a payment structure within the organization. We will need to form a network, a shared savings distribution program, and develop quality targets and metrics for accountability.

Currently, Alaska does not utilize Managed Care Organizations or Managed Health Plans. There are different kinds of managed care, and

we encourage you to structure any legislation broadly enough to allow for local innovation like CCO's. We believe that a provider-led model like a CCO will work on the Kenai Peninsula and we are willing to pilot it.

A CCO will have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. We believe a CCO will be better able to coordinate services and also focus on prevention, chronic illness management and patient-centered care. We would have flexibility within our budget to provide services alongside medical benefits with the goal of meeting the Triple Aim of better health, better care and lower per capita costs for the population we serve.

Thank you for the opportunity to testify and please give consideration to a global budget CCO demonstration in any legislation you discharge from the subcommittee.