February 16, 2016

To Senator Anna MacKinnon and Members of the Committee:

I am writing in support of the efforts towards Medicaid Redesign. It recently came to my attention that your committee has specifically requested feedback from primary care providers. I would like to share a few of my observations and thoughts to support Redesign efforts.

I am a Board-certified Family Physician who has been in Anchorage for 12 years. I am currently the Chief Medical Officer for Anchorage Neighborhood Health Center; prior to ANHC I was a Medical Officer and later Medical Director for the Alaska Psychiatric Institute. I have experienced the Alaska Medicaid system through the perspective of a community health physician providing continuity care and as a referring physician working with those experiencing serious mental illness who need to establish continuity care in the community. I have also participated as a stakeholder in the Medicaid Redesign process with DHSS and Agnew::Beck. I hope these experiences will give some credo to my opinions below.

Alaska's Medicaid program needs redesign—I need not explain how the costs are escalating and Alaskans are not necessarily 'healthier' for such expenditures. I believe that the efforts proposed for redesign through SB74 and SB78 will have a positive impact on the health of Alaskans receiving medical assistance and in the long-term will drive down costs for the State. In following I will share my opinions related to primary care initiatives, however I also welcome the opportunity to talk about Telemedicine or Behavioral Health Integration at a later date.

Primary Care is long-term, ongoing care based on a working relationship between a licensed health care provider and an individual (often termed a "patient"). A health care provider may be an Advanced Nurse Practitioner, Physician Assistant or Physician—the 'primary care' perspective relates to the scope of conditions that are managed. Primary care may include Family Medicine, General Internal Medicine (adults) or General Pediatric Medicine (infants and children) providers—the scope is all organ systems, awareness of socioeconomic and psychosocial factors driving 'wellness' and a longitudinal track of managing health conditions. That is, primary care is not focused on acute, one time or organ specific conditions—primary care identifies conditions that are often co-occurring and determines which conditions can be managed in the primary care setting and which conditions warrant referral/management to a specialist. *This is a key component of primary care that should have a positive reduction in Medicaid costs with an associated improvement in quality outcomes.*

Our current Medicaid system allows recipients to self-refer to specialists. Some specialists do require a primary care provider referral, but this is not a requirement. A medical assistance recipient can chose to see a different specialist for each physical symptom they are experiencing. This open access model can result in conflicting treatments, poly-pharmacy (prescribing multiple medications by multiple providers that may interact with one another), potential for morbidity (harm due to medical care) and increased costs to the payor (Alaska). By promoting and reinforcing a primary care perspective to health management, the medical assistance recipient has a single-point of reference who can synthesize the various physical symptoms in the context of the patient's personal history, family history and social

history, and determine a plan of care. More importantly, the primary care provider establishes a working relationship with the patient, and often their family, resulting in timely follow-up, follow-through, and more efficient use of healthcare resources. The primary care provider "closes the loop" to specialty referral through follow up appointments, follow through on treatment recommendations from the specialist and coordinating care for good outcomes. Thus the primary care provider can decrease costs to the payor (Alaska) by coordinating care with the specialists (versus a specialist and a primary care provider managing conditions parallel to one another).

Furthermore, counseling and identification of opportunities to prevent health conditions are hallmark in primary care settings. Primary care providers recognize the long-term savings (in cost and health) that can be acquired through screening and assessing a patient's risk for chronic health conditions. An example would be identifying the risk of cardiovascular disease in an individual, screening for diabetes in a person not experiencing any symptoms, or screening for breast cancer in a person with a family history for such. An individual does not need to see a specialist for these actions—they can all be achieved through a collaborative relationship with a primary care provider.

For those individuals with significant, co-occurring medical conditions—navigating the healthcare system efficiently can be overwhelming. For some, the simplest access to medical advice is through an emergency room—regardless of the severity of illness. Primary care providers routinely coordinate care for such cases and can reduce, and possibly eliminate, the misuse of emergency medical settings for non-emergent conditions. However, such coordination of care can be extremely time consuming in the clinic setting and is most efficiently managed by a care 'team' in the primary care setting. *A key to success for the Medical Redesign effort will be to financially support primary care settings to provide care coordination.*

Primary care providers often express pride in being able to manage multiple medical conditions and keep up to date with standards of care for multiple organ systems—however, there is a limiting factor to such complex care management: time. Coordination of care takes time—time to get a good history from a patient, time to perform a thorough physical exam, time to synthesize the information to form a diagnosis and plan, time to educate and inform the patient of that plan, time to review the patient's resources and likelihood of follow the plan, time to determine if there are other opportunities to screen for preventable conditions. One primary care provider, as an individual, will not have adequate time to do all these activities in a typical 20 minute clinic encounter. Yet leaving out one or more of those 'time' factors decreases the likelihood of success/health and increases the likelihood of costs/inefficiencies. Primary care initiatives must include a mechanism to support care coordination—this would most efficiently be managed through staff in a primary care setting, rather than additional state employees coordinating care via the Medicaid office.

Finally, I want to share my concerns about a potential risk with redesign efforts: lack of primary care provider access. Through stakeholder talks and conversations with peers in the community and state-at-large, there are realistic concerns towards providing care to medical assistance recipients. A general consensus is that if provision of care, and reimbursement for services, is too burdensome (i.e. paperwork) then private primary care settings will simply decline to accept Medicaid patients. If our private primary care providers 'close the door' to access for Medicaid patients there is a significant risk for a resultant surge of patients to community health centers and/or emergency rooms, overwhelming the community system of care and raises costs substantially. Think of it as a "supply:demand"

exercise—the demand for health care access is consistent to the number of medical assistance beneficiaries thus the success of cost-effectiveness to Medicaid Redesign will rely on the supply of primary care providers. *Medicaid Redesign needs to encourage the participation of primary care providers for care coordination, health and prevention efforts.* Primary care providers historically are paid less to do more. This is a hurdle that redesign efforts must acknowledge if you want vigorous and sustained participation by Alaska's primary care providers. My personal opinion would be to invest in care coordination through a viable *per-member-per-month* to primary care providers with an opportunity for *shared cost-savings* in cases previously identified as high-utilizers or inappropriate utilizers of the healthcare system. This mechanism rewards the value provided through a primary care setting and can offset the costs to a private primary care practice to hire a staff member specific to care coordination efforts.

I appreciate the recognition of primary care providers as a stakeholder to Medicaid Redesign by the Committee. I encourage you to be bold, thoughtful, and recognize that a system without correction for years cannot be rerouted in few months. An outcome of Medicaid Redesign must be a reinforcement of primary care ideals of long-term, collaborative care to improve health and move an individual towards wellness—through an individual's perception of wellness, cost savings and hence 'value' will be found for the state of Alaska.

Again, my thanks to you all for the opportunity to share my thoughts on primary care. If further insight to Behavioral Health Integration or Telemedicine would be of interest to the Committee or Chair, I would be happy to share my perspectives with you as well.

Sincerely,

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