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5 ALASKA HEALTH CARE COMMISSION
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9 TRANSCRIPT OF PROCEEDINGS
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12 March 31 - April 1, 2011
13 Baranof Hotel, Treadwell Room
14 127 N. Franklin Street
15 Juneau, Alaska
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ROSTER

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Commission Members Present:
Ward Hurlburt, M.D., M.P.H., Chair
Patrick Branco
C. Keith Campbell
Valerie Davidson
Jeffrey Davis
Emily Ennis
Paul Friedrichs, M.D.
T. Noah Laufer, M.D.
David Morgan
Lawrence Stinson, M.D.

Ex Officio Members:

Linda Hall
Senator Donny Olson, M.D.
Representative Wes Keller

Executive Director, Deb Erickson

1 Others Present March 31, 2011:

2 Jason Hooley, Office of the Governor

3 Rich Wooten, Assistant to Deb Erickson

4 Mark Foster, ISER

5 Joe McLaughlin, DHSS (telephonic)

6 Andrea Fenaughty, DHSS (telephonic)

7 Paul Cartland, DHSS

8 Delisa Culpepper, Alaska Mental Health Trust

9 Pat Jackson, Alaska Native Tribal Health Consortium

10 Beverly Smith, Christian Science Committee on Publication

11 Sandra Heffern, Community Care Coalition

12 Keith Busch, Center for Medicaid Services

13 Shelley Hughes, Alaska Primary Care Association

14 Tom Chard, AMHB/ABADA

15 Lyn Freeman, Mind Matters Research, LLC

16 Denise Daniello, Alaska Commission on Aging

17 Others Present, April 1, 2011:

18 Rich Wooten, Assistant to Deb Erickson

19 Mark Foster, ISER

20 Duane Mayes, Division of Senior & Disability Services

21 Joanne Gibbens, Division of Senior & Disability Services

22 Millie Duncan, Wildflower Court

23 David Cote, Division of Pioneers Homes

24 Sandra Heffren, Community Care Coalition

25 Kay Branch, Alaska Native Tribal Health Consortium

Denise Daniello, Alaska Commission on Aging

Nancy Burke, Alaska Mental Health Trust Authority

Pat Jackson, Alaska Native Tribal Health Consortium

Emily Nenon, American Cancer Society

Brenda Parnell, SEARHC

Scott Ciambor, Juneau Economic Development Council

Ralph Wolfe, Senator Kookesh's office

Peter Naoroz, Kootznoowoo

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1 THURSDAY, MARCH 31, 2011

2 8:00 A.M.

3
4 WELCOME AND INTRODUCTIONS

5
6 CHAIRMAN HURLBURT: I'd like to
7 welcome everybody here. As we're getting started,
8 I'd like to just bring everybody up to date on a few
9 news items here.

10 Commissioner Streur is not going
11 to be able to be here with us. He'll be in Barrow
12 today, actually, leading the parade on behalf of
13 the Governor on domestic violence and sexual abuse.
14 But he sends us his regards, and he was sorry that
15 he was not going to be able to be here.

16 We've all been reading the news,
17 seeing what's happening, reading particularly about
18 Ohio, Indiana, and Wisconsin and what they're doing
19 to control costs. And the news item this morning
20 said Governor Pat Quinn, who is more on the other
21 side of the political spectrum than those three
22 states, said, "It's just plain wrong. I don't buy
23 into all these radical cuts in government as a way
24 to make life better for ordinary, everyday people."

25 Last weekend, Commissioner Streur

1 was in Washington meeting with his counterparts.
2 About maybe a little more than half of those around
3 the country had enough money left to buy an
4 airplane ticket to get to Washington for the
5 meeting. And his new counterpart, as the secretary
6 of the department in Illinois that contains
7 Medicaid, contains public health was there, a woman
8 who he met for the first time. And she had just
9 found out that she has to cut her budget
10 22 percent. This is in a liberal state that is
11 saying, "We're not going to make these terrible
12 cuts."

13 That's the world we're in today,
14 and that's what we're talking about. Again, we
15 have incredible blessings here in Alaska, along
16 with a couple of other states, that we're not quite
17 that dire. But this was in a state where the
18 Governor was saying what these other folks are
19 doing is terrible, and she just found out
20 22 percent. Can you imagine what that would do if
21 that happened here for Medicaid and public health
22 in our state?

23 This morning's Wall Street
24 Journal -- Dave Wessel, who is a regular economic
25 columnist there -- and the headline was, "Fiscal

1 health of the United States hangs on containing the
2 costs of care." So, again, a charge to us here.

3 A couple clinical updates. One of
4 the shock-and-awe slides that I have used had to do
5 with a drug for advanced prostate cancer, PROVENGE.
6 Medicare just came out -- you'll be relieved to
7 know that Medicare said, "We're not going to ration
8 care. We're going to approve paying for PROVENGE
9 for these advanced prostate cancer patients, who,
10 on the average, live four months more with this
11 \$93,000 drug for one dose. And that's what we're
12 going to do."

13 Now, for those of you who have
14 been to Maui, which is where my wife and I like to
15 go, if you're divers, you know if you go to Makena
16 Landing, that's a good place to see sharks in the
17 caves, if you go scuba diving there.

18 There is a drug, an old drug with
19 a new name, called Makena. Progesterone is a type
20 of drug that's been around for many, many, many
21 years; longer than I've been in the medical field.
22 And currently -- and I've mentioned this before --
23 there has been quite a bit of enthusiasm that a
24 progesterone-type drug could reduce the risk of
25 premature birth in women who have had a previous

1 premature singleton -- meaning one baby -- birth if
2 they have delivered before 34 weeks. And probably
3 most obstetricians in the country are quite
4 enthusiastic about this.

5 I think that the answer is still
6 not there. Hayes, which is the company I've
7 mentioned that does the efficacy studies and
8 looking at how good various interventions are,
9 gives it a C, which means that the evidence is not
10 in. It's not conclusive. But it is widely used,
11 and there were a lot of believers. And with
12 Medicaid providing about half of the deliveries in
13 our country now, a lot of Medicaid recipients
14 received it. The company that I worked with before
15 coming back to Alaska was very much into it, and we
16 encouraged our women to use it.

17 The cost -- it was compounded by
18 the local pharmacies. It costs \$10 to \$15, and
19 this is ringing a bell, I think, for some of you --
20 in the headlines, you've seen that. It costs \$10
21 to \$15 to make up. It was given weekly, starting
22 between weeks 16 and 20 and continuing through week
23 34; so about 20 weeks during the pregnancy there to
24 try to reduce the chances of premature births.

25 And those who did economic

1 calculations figured that for about every dollar
2 spent for the drug and the cost of the
3 administration, you probably saved about \$8 to \$12
4 on economic consultation.

5 Well, in its wisdom, the FDA
6 awarded a sole-source license to a pharmaceutical
7 company called KV to make this drug, and they
8 called it Makena -- which I will think about when I
9 see the sharks, I think. But it will now cost
10 \$1,500 a dose instead of \$10 to \$15 a dose; so
11 about \$30,000 during the course of a pregnancy.
12 And the risk/benefits ratio has changed from about
13 1 to 12 positive, so now you'll spend about \$12 for
14 every dollar that you may save in the hospital cost
15 for premature babies.

16 Now, fortunately, the FDA, in the
17 last couple of days, has come out -- because the
18 drug company sent notices to all the compounding
19 pharmacies around the country and said, "You better
20 stop this, or the FDA is going to come after you,
21 and we're going to come after you, and you are
22 going to violate the license that we've been
23 given." The FDA has formally said, "We have better
24 things to do. We're not going to do that."

25 And so I think that there has been

1 a real groundswell among obstetricians, among
2 Medicaid programs, among others in this country
3 against this egregious thing. The NIH paid the
4 \$5 million for the efficacy studies that they did
5 on the drug. It wasn't a drug company, but the
6 drug company got the license.

7 So that's our milieu. That's the
8 update on the news for this morning, but I think
9 it's the tone we need to remember every time we
10 meet. And as we talk about our charge for Alaska
11 related to accessibility and quality of care and
12 affordability of care, we need to keep the costs of
13 the care that we have a part of the national
14 picture that we have here.

15 I'd like to start and maybe have
16 each of the commissioners introduce yourselves. We
17 can go around the table. And then we'll go out to
18 the public members here that are visiting with us.

19 Keith, could you we start with
20 you?

21 MR. CAMPBELL: Certainly. Keith
22 Campbell. I'm the consumer representative on this
23 commission. My background is I live in Seward, and
24 I spent many years as a hospital administrator.

25 REPRESENTATIVE KELLER: I'm Wes

1 Keller, Representative, Chair of the House Health
2 Committee. And I'm an ex-officio, non-voting
3 member.

4 DR. STINSON: Larry Stinson. I'm
5 one of the physicians on the committee, and we
6 practice in Anchorage, Fairbanks, and Wasilla.

7 MS. ENNIS: Good morning. I'm
8 Emily Ennis. I represent the Alaska Mental Health
9 Trust. I'm from Fairbanks, where I'm executive
10 director of a nonprofit, providing long term care
11 and other supports to individuals and children with
12 disabilities.

13 MR. MORGAN: I'm Dave Morgan. I
14 represent community health centers, the Primary Care
15 Association.

16 CHAIRMAN HURLBURT: Jason?

17 MR. HOOLEY: I'm Jason Hooley. I'm
18 Governor Parnell's Director of Boards and
19 Commissions. I'm here just to make brief comments
20 and to wish you welcome.

21 CHAIRMAN HURLBURT: Thank you.
22 I'm Ward Hurlburt. I'm the
23 Director of Public Health, Chief Medical Officer of
24 the state, and chair of the commission.

25 MS. ERICKSON: I'm Deb Erickson,

1 Executive Director of the commission.

2 COL. FRIEDRICHS: Paul Friedrichs,
3 Air Force urologist.

4 DR. LAUFER: Noah Laufer. I'm a
5 primary care doc in Anchorage.

6 MR. DAVIS: I'm Jeff Davis from
7 Premera Blue Cross Blue Shield of Alaska,
8 representing insurers and all Alaskans everywhere.

9 MS. DAVIDSON: Nurr'avaaluk Valerie
10 Davidson. I work at the Alaska Native Tribal Health
11 Consortium, and I represent the tribal health
12 system; but I'd like to think, like Jeff, I think we
13 all represent all Alaskans.

14 MR. BRANCO: I'm Pat Branco. I'm
15 the CEO of Ketchikan General Hospital, and I
16 represent the state hospital association and nursing
17 home association.

18 MS. HALL: I'm Linda Hall, Director
19 of the Division of Insurance. I'm an ex-officio
20 member, representing the Governor's office.

21 CHAIRMAN HURLBURT: Deb, could you
22 introduce Rich?

23 MS. ERICKSON: I would be very,
24 very, very happy to introduce Rich.

25 So, everyone, this is Rich Wooten.

1 He's our brand-new admin. assistant. He started
2 the day before yesterday and has jumped in with
3 both feet. I dragged him down here from Anchorage
4 with me, and he's already been a tremendous help.
5 So I'm really looking forward to having his support
6 for all of us.

7 And I thought I would just
8 introduce quickly, too, and then we can go around
9 the room -- Lynda Barker is going to be our
10 stenographer today. Thank you, Lynda.

11 And Betsy is working our sound
12 board. And is there anything that's obvious to
13 folks -- we're used to using mikes that have push
14 buttons to talk. Betsy is actually going to be
15 turning you on when it's your turn to talk, and
16 just remember to hold the mike close.

17 And I think other than that, we
18 probably can go around the room.

19 CHAIRMAN HURLBURT: Okay. Mark,
20 could we start with you and then go around the room?

21 MR. FOSTER: Sure. Mark Foster,
22 consultant to the Health Care Commission, the state
23 hospital association, and a number of other clients,
24 focusing on costs and evaluations.

25 MR. CHARD: Tom Chard with the

1 Alaska Mental Health Board and the Advisory Board on
2 Alcoholism and Drug Abuse. Good morning.

3 MR. BUSCH: Good morning. My name
4 is Keith Busch. I'm with the Center for Medicaid
5 Services. I'm the Alaska representative.

6 MS. JACKSON: Good morning. I'm
7 Pat Jackson. I work for the Alaska Native Tribal
8 Health Consortium.

9 MS. HUGHES: Good morning,
10 everyone. Shelley Hughes with the Alaska Primary
11 Care Association, government affairs specialist.

12 DR. FREEMAN: Good morning. Lyn
13 Freeman, Mind Matters Research.

14 MS. SMITH: Bev Smith, the
15 representative for Christian Science in Alaska.

16 MS. CULPEPPER: Delisa Culpepper
17 with the Alaska Mental Health Trust Authority.

18 MS. HEFFERN: Sandra Heffern,
19 Community Care Coalition.

20 CHAIRMAN HURLBURT: Welcome to
21 everybody. And we will be having some others join
22 us, I'm sure.

REVIEW MEETING RULES

1
2
3 CHAIRMAN HURLBURT: We want to talk
4 a little bit about just ground rules for the
5 meeting, and Deb and I have talked about this. It
6 probably will be a little more formal than we have
7 been historically, recognizing that maybe, with a
8 larger group, that's probably going to be an
9 appropriate approach.

10 And Deb will go over our agenda
11 for this meeting.

12 MS. ERICKSON: Sure. And hopefully
13 we'll be able to read these. We're trying not to
14 blind Dr. Hurlburt, so half of our slides are going
15 to be on the ceiling, except when we actually have a
16 more formal presentation. Then folks up front can
17 move to the side so can we can lower the screen
18 there.

19 So as Dr. Hurlburt was mentioning,
20 we're still adjusting, and I think now we feel like
21 we have more breathing room to adjust further to
22 having a larger size group. And where we had the
23 smaller group, I was -- one of the things I was
24 reflecting on over the weekend, after a dinner
25 party -- I like to host dinner parties. And over

1 the years, I found that it's not better or worse,
2 but there is a certain size that you can engage
3 everybody around the table, and it's usually about
4 8 to 10. Everybody can be engaged in a
5 conversation together.

6 But if it gets to be a group of
7 more than 10, we can still -- my husband will
8 actually put tables together so everybody can still
9 sit all around a large table together, as many --
10 we've had as many as 20, I think, around one table
11 together. But when you get over 10 people, it's
12 just not possible to have a single conversation
13 among the whole group. Lots of little
14 conversations start.

15 And so I was just reflecting on
16 that when I was thinking about it and still
17 grieving a little bit the fact that when we had a
18 group that was 10 members, we were able to have a
19 more free-flowing conversation, and everybody could
20 engage. And now that it's a larger group, again,
21 it's not better or worse; it's just different. And
22 we are going to need to be a little more formal in
23 our approach to managing the conversation so that
24 everybody gets a chance to talk.

25 And we can't just allow -- as much

1 as I appreciate the conversation that can flow when
2 we get on a topic that folks are really interested
3 in, we're going to try to be a little more formal
4 and ask that everybody who wants to talk raises
5 their hand. And we'll try to keep track a little
6 bit of how many times folks are talking or not
7 talking. And at some point, if it gets too hard, I
8 might even ask Rich to take a little bit of a
9 tally, so we can make sure we're going around the
10 table periodically. You know, this isn't school,
11 but maybe putting some of the folks who aren't
12 speaking up too much on the spot to share their
13 thoughts.

14 And so I pulled some of our
15 meeting rules. Our full meeting rule sheet is on
16 pink paper behind the agenda. But I just pulled a
17 few highlights related to these thoughts off that
18 sheet right now.

19 And we've reviewed all of these in
20 the past, but I thought I would just highlight that
21 we practice active listening, that we respect each
22 other's differences around the table, that we share
23 the floor, and that we can expect everybody to
24 participate and try to stay on topic and focus as
25 much as possible. So those were the only meeting

1 rules I thought I would hit.

2 One of the things that I thought I
3 would cover, too, briefly -- and we can have a
4 little more conversation about this with our
5 legislators.

6 But, Rich, if you would go to the
7 next slide.

8 Some of the guiding principles
9 that we have talked about in the past -- and
10 starting with our very first meeting of the first
11 group -- that we would focus on being proactive and
12 designing our own agenda and not reacting to and
13 commenting on legislation or regulations when they
14 come out from the state or the federal government,
15 that we focus on a long term view and not
16 short-term, immediate crises. That's the comment
17 about avoiding succumbing to the tyranny of the
18 urgent.

19 And just a note about that, that
20 unlike more political processes, we have a little
21 bit of a luxury to take more of a long term view
22 and aren't having to address issues within just a
23 one- or two-year period.

24 That we're attempting to stay at
25 the 50,000-foot level, not getting down into the

1 weeds and defining how organizations or government
2 agencies are going to operate or do their business;
3 that we're focusing more on global policy
4 recommendations and focusing on what policies need
5 to be in place, not how they're going to be
6 implemented.

7 We're doing our best to stay
8 apolitical. And we need to be mindful that any
9 recommendations that we might make on something
10 that is particularly a hot topic politically in the
11 newspaper and in the government sector right now
12 might be viewed as taking sides, and we need to be
13 mindful of whether we'll be -- why we're making a
14 particular recommendation and if we're actually
15 really adding any value to improving health and
16 health care in this state.

17 One other thing I would just
18 note -- the "no lobbying allowed." I had a
19 legislator contact me personally, in person,
20 twice -- talked to me, approached me and talked to
21 me in person -- who had been at our last meeting
22 and was concerned -- and I knew that this wasn't
23 the case. This wasn't the intent -- but she'd been
24 approached by a commission member with some
25 questions at one point, and I think she felt -- she

1 specifically told me, "This isn't the role of the
2 commission." Whatever was discussed with her she
3 felt that the approach wasn't appropriate.

4 And so it's just -- especially for
5 those of you -- some of you are more expert than
6 I'll ever be and more experienced than I'll ever be
7 in working with state policy development and
8 working in the political world -- and in state
9 government, specifically, which is way different
10 than other levels of government. Either way.

11 But it's just something to keep in
12 mind, is that we're trying to stay apolitical and
13 focusing on real global policy issues. And that, I
14 think, will help avoid stepping in those little
15 traps inadvertently.

16 REVIEW AGENDA

17
18
19 MS. ERICKSON: So those are just
20 some thoughts on our guiding principles. Let me
21 review our agenda just really quickly. I think
22 what -- and I won't have you use any more slides
23 right now, Rich.

24 Just a reminder: We described in
25 our 2010 plans where we're at in terms of studying

1 the current system and the issues that we're going
2 to continue studying this year. So part of our
3 agenda for the year is to study certain issues.
4 And part of our agenda for the year is to spend
5 some time studying some specific strategies for
6 improvement, areas that we might want to make
7 recommendations around, develop policy
8 recommendations around.

9 And so each of our agendas, each
10 time we meet this year, are going to be focused
11 on -- we'll spend a little time learning more about
12 the current system and part of the time talking
13 about potential strategies and learning about
14 those.

15 And at the end of the meeting, for
16 next steps -- and I've actually listed it on the
17 agenda -- plans for upcoming meetings, just for a
18 simple list. It's kind of mixed together, but
19 things that we'll study both to understand the
20 current system and as potential strategies for the
21 future. But just keeping that in mind for context.

22 What we're going to do today -- we
23 had a conversation at the end of our last meeting,
24 just still struggling a little bit in our forming
25 stage with what the Governor's and Legislature's

1 expectations of this group might be. So we're
2 going to have a few comments this morning. That's
3 why Jason is joining us. He's going to have to
4 leave as soon as he's done, because he has business
5 he needs to get back to in the Governor's office.

6 Hopefully Representative Keller
7 will be able to be with us as much as possible, but
8 this is a really busy time in the legislative
9 session too.

10 And we're expecting Senator Olson
11 this morning, but it's particularly busy for Senate
12 Finance right now. So I expect he'll be in and
13 out.

14 But we'll have some -- just a
15 little bit of time to hear from them specifically
16 on their expectations.

17 Then we'll get into a learning
18 mode. Mr. Foster has some preliminary information
19 to share with us on his cost analysis so far. And
20 we'll spend some time talking about that, too,
21 after his presentation. We'll have more time for
22 conversation.

23 One of the things that you all had
24 asked for in our last meeting is if we could come
25 up with some specific definitions for health,

1 health care, health care system, health care
2 continuum. I've put together some draft ideas for
3 you, shared them in your pre-meeting notebook, and
4 we'll have that conversation later in the morning.

5 We're breaking a little early for
6 lunch -- hopefully it won't be raining too hard --
7 for any of you interested in participating in the
8 "Choose Respect" march, but I included a flier in
9 your first section behind agenda for the -- there
10 are, I think, 40 different communities at least
11 across the state today at noon are going to be
12 participating in a rally against domestic violence.
13 And so anybody interested in participating in that,
14 we have more time on the agenda to do that now.
15 And I also included a map of the route that we can
16 follow -- that the march will follow.

17 We will have -- one of the things
18 I wanted to mention: This meeting is only going to
19 be teleconferenced for the public hearing; but we
20 have contracted with Gavel to Gavel, and we're
21 being -- we have a live audio stream going right
22 now, so folks are able to listen to the meeting but
23 are -- will only be able to participate in talking
24 back with all of you during the public hearing
25 process from 1:00 till 2:00.

1 Then we'll spend some time on
2 health information technology. I'll introduce that
3 session a little bit more later this afternoon.

4 Dr. Hurlburt and Linda will give
5 us an update on some related initiatives,
6 specifically the Medicaid Task Force and Affordable
7 Care Act later this afternoon.

8 And then we'll just wrap up with
9 some real quick business, reviewing our new
10 financial disclosure form -- which is still being
11 drafted. If you have a chance to look at that and
12 see if you have any questions so we can adjust it
13 if it needs more clarification.

14 Financial status -- I'll just
15 update you on the contracts that we have in place
16 or are working on getting in place.

17 And then, finally, tomorrow we'll
18 spend the majority of our morning learning about
19 and discussing long term care in Alaska.

20 Does anybody have any questions
21 about our plans for this meeting or about how your
22 notebook is laid out?

23 And for those of you who might be
24 listening to the audio stream over the web, several
25 of our handouts and presentations are posted on the

1 commission's website on the March 2011 web page.

2 And one of the things I'll just
3 note is that folks listening will not be able to
4 see Mark Foster's presentation, and you all are not
5 going to be getting a handout of that, and we won't
6 be posting that to the web, because the data and
7 analysis right now is preliminary, and we don't
8 want it to get out there and misused, potentially,
9 before it gets finalized. But I thought just I
10 would note that for the listening audience on the
11 other end. I think that's about it.

12 Ward, if you want to start with
13 Jason, and then give Wes an opportunity to say a
14 few words and see if folks have questions.

15
16 ROLE & SCOPE OF COMMISSION
17

18 CHAIRMAN HURLBURT: Yes. As Deb
19 said -- and, again, this relates to our larger group
20 on the reconstituted commission here. We thought it
21 would be wise to go back and to get an understanding
22 of what the expectations are.

23 We're charged with an annual
24 report, January 15th each year, to both the
25 Governor and to the Legislature with

1 recommendations related to the work that we've done
2 during the preceding year.

3 And so Jason Hooley, who vetted, I
4 guess, everybody here, at least all the recent
5 members -- I'm not sure how far back you go -- but
6 was very much engaged in knowing about you and
7 presenting your names as one of the choices to the
8 Governor, who then selected each of us, except for
9 the three statutory members that are going to be on
10 the commission.

11 So Jason -- it's a really busy
12 time for Jason and for Representative Keller and
13 others here in Juneau, but we really appreciate
14 your coming and would appreciate your perspective
15 on what you see as the expectations for the
16 commission, Jason.

17 MR. HOOLEY: Thank you, Mr. Chair.

18 Many of you know me. For those of
19 you that don't, I'm Jason Hooley, Governor
20 Parnell's Director of Boards and Commissions. I
21 live and work here in Juneau, and I help him decide
22 who to appoint to our various boards and
23 commissions. We have about 130-some boards and
24 commissions.

25 Even though I'm kind of on the

1 spot now, and I've got a microphone in my face,
2 this is my favorite part of my job is actually
3 showing up to a board meeting and watching you work
4 and realizing that there's people out there who are
5 committed, who are not just a resumé on my desk or
6 a voice on the other end of the phone, but there is
7 actually a product out there that people are
8 working hard towards.

9 I'm just pleased to be here and
10 offer some brief comments here as you kick off your
11 meeting. I won't take up much of your time. A lot
12 of my comments I think echo Deb's introduction as
13 well, but just thank you for your hard work on
14 behalf of the Governor's office. I know it's a
15 sacrifice and it's definitely a public service, but
16 we really appreciate your efforts here. And it's
17 not lost on us, the work that you do.

18 With that said, I wanted to
19 revisit the Governor's goals for this commission.
20 As we all know, health care is an increasingly
21 important and complex and expensive priority for
22 all of us Alaskans. The Governor has asked you to
23 deliver recommendations that are designed to
24 address increased health care access for all
25 Alaskans, control costs, improve health care

1 quality, and the identification of prevention-based
2 strategies.

3 And recognizing the natural
4 pressure to weigh in on various pieces of state and
5 federal legislation and also understanding the
6 input that you guys receive from various interests
7 who lobby for their goals, I just want to encourage
8 you to focus on those recommendations.

9 The Governor's office is looking
10 to the commission to craft an Alaska-based solution
11 for improving the health care affordability,
12 quality, and access, and he wants your
13 recommendations. And rather than focusing on how
14 an idea will be implemented or delving into the
15 specific operational details of the
16 recommendations, rather the Governor is just
17 looking for general policy advice on what needs to
18 happen to improve health care and the "how" can be
19 sorted out between the administration and the
20 Legislature.

21 And that's about all I came to
22 say. I really appreciate what you do, again, and
23 to see you guys here working is encouraging to me.
24 And I appreciate Deb's plug for our domestic
25 violence and sexual assaults campaign that will be

1 going on today. There is actually over 60
2 communities now that have joined in that effort and
3 have signed on to have various rallies and marches
4 today, and I'll be proud to take part in that here.
5 Wish you well.

6 I wish you well, and if there is
7 anything we can do for you to support your work
8 here, Deb has got my contact information. I'll be
9 glad to talk with you about that.

10 And I got to run up the hill.
11 It's a busy day up there, but thank you for your
12 time and good luck.

13 CHAIRMAN HURLBURT: Any quick
14 questions for Jason before he needs to go?

15 Thank you very much, Jason. I
16 appreciate you coming.

17 Representative Keller, I guess
18 you'll speak for the entire Legislature, it looks
19 like.

20 REPRESENTATIVE KELLER: You know
21 how to strike terror into my heart. Speaking for
22 the whole Legislature is not something I usually do.

23 The reason we're all here and the
24 reason that the Legislature, I believe, passed the
25 legislation that put us in place is the problem

1 that we have ahead of us, and that is: We have an
2 unsustainable health care system. It's as simple
3 as that. At some point, there is an end to all of
4 the good times here. And I think most of us at
5 this table agree with that. We all have a glimpse
6 of the cliff that's ahead of us, and we really need
7 to act.

8 And it's not just Alaska.
9 Interestingly enough, we have a better opportunity
10 than most states, because we're still okay
11 financially, and we're looking ahead. This
12 commission is evidence of that. There are things
13 that can be done. We have a better opportunity
14 than most.

15 This commission has a golden
16 opportunity, I believe, to do something great; but,
17 frankly, the odds are against us. If you look at
18 other commissions and task forces and that kind of
19 thing, they usually don't make it. And part of the
20 reason is very obvious. We're ultimately a
21 committee here -- right? -- so we have to come to
22 some kind of a consensus on what we're doing, and
23 sometimes that's very difficult.

24 And then, when we get done, if
25 it's something where it takes a policy change in

1 law, we got to go to the worst committee of all --
2 no, the best committee of all, the Legislature, of
3 which I'm one of 60. In fact, I'm in the House,
4 and I think I'm 26th in the seniority. So I'm not
5 in leadership, and I'm not up there in the
6 responsibilities there, but I am very proud to
7 represent them with you.

8 The only hope we really have here
9 is if we get together and come up, in the end, with
10 unanimity and collaboration and make the -- keep
11 our goal right in front of us, which is: Let's
12 make recommendations here to the Legislature, to
13 the Governor, to the departments on what to get
14 done.

15 And to do that, we have to -- the
16 real secret here is how we work together and how we
17 relate to each other. And we have to make who we
18 represent secondary, at some level, to what we're
19 doing. You know, there is an irony built in here.
20 We are all appointed to represent somebody, right?
21 And we come here as a group and we got some -- what
22 I'm going to call a constituency, that we want to
23 make sure that we're in the mix here. This is
24 important. That's one way to look at it.

25 Another way to look at it is, of

1 course, is we bring -- for the ones that
2 understand, I try to -- in my limited ability, try
3 to represent where the Legislature is coming from.
4 You know, that's what I am here.

5 But there is, at some point --
6 okay. If I come in here every time and try to come
7 up with legislative fixes or, you know, whatever
8 for whatever we got to do, you're going to get
9 pretty upset with me, and rightly so. But we
10 just -- I'm just saying that, as we look at who we
11 represent, at some level we need to make it
12 secondary.

13 We all have -- I would say we all
14 have at least high potential for conflicts of
15 interest. And I think we need to be brutally
16 honest with one another with that, be right up
17 front with it. For example, if this commission is
18 successful, you know, and if it takes legislation
19 to get it done, Donny and I are pretty good at
20 that, and that's not bad for a politician -- right?
21 -- to look good.

22 So what I'm saying is that I have
23 -- we all come -- you know, whether it's financial,
24 whether it's credibility for ourselves, or wherever
25 we have a conflict of interest, I think part of the

1 way we can work together the best is to be real
2 straightforward with each other on those things and
3 maybe make sure we review our bylaws to make sure
4 we have the appropriate conflict of interest issues
5 addressed.

6 Because it becomes an issue when
7 we make a recommendation too. If we come to --
8 with a recommendation for legislation, you know, if
9 we are all up front, everybody is used to -- Alaska
10 is a small town. Everybody is used to the fact
11 that we're professionals in our field, and,
12 therefore, we advocate for. But if we're right up
13 front with that, you know, that kind of solves the
14 problem. So that's really important.

15 We'll try not to -- I'll try not
16 to come to these meetings and be thinking of
17 everything in the context of legislation; but,
18 frankly, the Legislature approves the budget, you
19 know, and approves policies. So I'll try to be a
20 resource to you. That's my intent.

21 So, in summary, keep the goal in
22 mind. We want to come up with a sustainable plan,
23 health plan for Alaska, make recommendations to
24 that end, to the Governor and to the Legislature.
25 That's what we want. That's what it's all about.

1 Be brutally honest with ourselves and each other as
2 far as our own self-interests that may be there,
3 and just put that on the table; and try not to be
4 simply an advocate for the people you're here to
5 represent.

6 As far as today is concerned, it's
7 actually, believe it or not, the most significant,
8 in my estimation, vote of the year for the House.
9 We have the tax bill up today on Resources. So I'm
10 going to go up in a little while and punch in that
11 I'm there, and then I'm going to disappear -- and
12 this is all cleared with leadership -- and come
13 back down. Because I really do -- this is very
14 important business here, what the commission is
15 facing.

16 If the troopers show up, I didn't
17 do anything wrong. That just means somebody put a
18 call on the House, and they want me up there for a
19 vote, you know. So it is an intense day on the
20 hill. You know, Jason wasn't kidding. So at about
21 10:20 I'll be heading out, and then I'll be back as
22 soon as I can. So, thank you. If there are any
23 questions, I'd be happy to respond.

24 CHAIRMAN HURLBURT: I think it will
25 be important to take a little bit of time for some

1 discussion. But I'll say Senator Olson is not able
2 to be here now, but Deb and I both have met with
3 other members of the Legislature -- Representative
4 Hawker, who has had to slow down a little bit this
5 year because of his health problems but is intensely
6 interested and sees this as very important.

7 Jason mentioned that there are
8 130-some boards and commissions, so you'd say,
9 "Well, we're just part of the wallpaper on that."
10 But I think the realty is there is intense interest
11 because of the challenges that we face, both across
12 our whole society and the economy here, and very
13 specifically of what's happening to state
14 government with the demands for the costs of health
15 care.

16 And so Representative Hawker has
17 very directly expressed to me his hope and his
18 vision that we would be a real resource and a real
19 asset to the Legislature and to the Governor in
20 addressing those kinds of issues.

21 Senator Davis has been here.
22 We've all seen her come in several times, and the
23 members of the Legislature do not need to look for
24 extra meetings to go to. If they come and like to
25 visit with us, it shows that that's important. And

1 she, of course, with her personal background and
2 her assignments there related to health -- but is
3 very interested in what we do. And we've seen
4 other members of the Legislature come. So, yeah,
5 we're one of 130-some, but we're dealing with
6 something that's critically important to us.

7 And I suspect my bias is that we
8 haven't really crystallized on it enough, but we
9 know that, somewhere out there, that it could
10 happen, that Commissioner Bill Streur could be told
11 by the Governor, "You've got to cut 22 percent,"
12 and that would be awful. That would just be slash
13 and burn. So I think, you know, we've got some
14 time, because we're lucky in Alaska, but that's
15 important.

16 So I'd like to, if we could --
17 and, again, kind of putting Representative Keller
18 on the spot, representing his other 59 colleagues
19 in the Legislature there. But I think we should
20 really seek to have some clarity for all of us, if
21 there are some issues, of what are the
22 expectations. And he just gave a very nice outline
23 of what that is, but I think this is the time to
24 bring that up and to talk about that and to get any
25 clarity. So I'm going to open that up.

1 Keith?

2 MR. CAMPBELL: I guess I've been
3 wrestling with where we're trying to go with, quote,
4 the system. We have -- as it's said in here, we
5 have three basic systems, and yet there is no -- at
6 least in my mind, and my experience is that there is
7 no real czar or some focal point to really try to
8 force some continuity and -- I'm searching for words
9 here -- but so that we do get more rationality and,
10 therefore, I would hope more efficiency out of the
11 system.

12 I read the documentation here and
13 have a lot of questions later on on some of this
14 that we received -- the documents that we received.
15 And let me refer to some of it here.

16 The futurist documentation here is
17 very good, but it seemed to me that, in Alaska,
18 he's talking about choice, if I read it right,
19 interpreted it right. But most of us in Alaska
20 have very little choice.

21 I live in a small town. I've got
22 what's there or what an airplane ride can give me
23 at the tertiary centers. I have basically -- I'm
24 lucky to have the choices I have. The same in much
25 more rural Alaska. And I suspect maybe -- I don't

1 know Anchorage intimately -- but that you may be
2 captive of what's available to you. I'm thinking
3 Medicare, the providers that do these sorts of
4 things. The colonel's constituency is captive.

5 So this idea of choice is
6 wonderful, but I just am wrestling with how we get
7 our hands around that sort of thing and the
8 anticipated efficiencies that this document points
9 out.

10 That's all I've got at this point,
11 but I'm still wrestling with how we get as
12 efficient as everybody wants us to get. So
13 somebody better be a genius on this one.

14 REPRESENTATIVE KELLER: If I could
15 respond, that's what -- it's interesting that this
16 would come up in the context of the Legislature,
17 because nothing is as inefficient as the
18 Legislature. The way it's designed is that there's
19 different representations, and any recommendation
20 that anybody comes up with as a policy change, it
21 would start out in the House one way, and you're not
22 going to get what you think at the end.

23 So I wish -- I'd like to sit here
24 and say, "Yes. Just give us some recommendations
25 here, and we can put them in line there. You got

1 your efficiency." But it isn't going to happen, so
2 we have to be smarter than that. And we have the
3 ability to do it in this commission.

4 This is what I neglected to say,
5 is that this commission is held in high esteem in
6 the Legislature. I -- at least from my
7 interactions with my peers, I have never heard
8 anything negative. I've heard nothing but
9 appreciation. Even on -- when we skated on the
10 edge here, when the ObamaCare passed and we asked
11 Deb to come in and say, "Hey, give us a briefing
12 here," that we went away with a lot of credibility
13 because of her work there. It was really good, you
14 know, really fine.

15 So we aren't going to be able to,
16 from the legislative perspective, provide that; but
17 as a commission, we need to get -- really roll up
18 our sleeves and make recommendations as a unit,
19 both to the Legislature and the Governor, if
20 anything is to succeed. And then, individually, we
21 probably need to follow through, you know, with the
22 politics. We probably can't do that as a -- you
23 know, but that's how you maintain an idea once it
24 starts out.

25 CHAIRMAN HURLBURT: Yes, Pat.

1 Please.

2 MR. BRANCO: Representative Keller,
3 when you talked about the cliff on the horizon, one
4 of the things that any group, any person tends to do
5 is find out why we have approached this and look for
6 the points of what caused it, but also who is to
7 blame for getting there.

8 So I hope the Legislature and this
9 commission work really hard -- how many are
10 familiar with the word -- the term "root-cause
11 analysis"? A few people are. It's not a common
12 phrase for everyone; but in health care, it's a
13 shift that we've done to take away the blame
14 element and find out the processes that occurred
15 that allowed this to happen.

16 And so without discounting our
17 historical pieces that brought us to the
18 brinksmanship moment, it's really careful -- we
19 need to be very careful not to look for the "who is
20 to blame," but find the process that occurred so
21 that we don't repeat those processes and find a
22 real way to make it -- the ultimate goal of a
23 root-cause analysis is to create a process that
24 allows it to never happen again. And so I think
25 that's good watchwords for all of us.

1 CHAIRMAN HURLBURT: Go ahead.

2 REPRESENTATIVE KELLER: Great
3 comments. How can I resist? You know, those that
4 have been on the commission with me for a while know
5 that I have not gone there, but the root-cause
6 analysis -- in my mind, oversimplified compared to
7 the way this is applied -- has to do with the
8 market, of course. But, you see, it's interesting,
9 because that, in and of itself, could be a divisive
10 thing between us. But I think we have to be right
11 up front with those kind of things, where we're
12 coming from.

13 Where I'm coming from, frankly, in
14 response to that is the root cause is the market
15 isn't working. People don't know what they're
16 buying. It's okay if we spend twice as much as
17 we're spending on health care as we are right now,
18 as long as we know the value of what we're buying,
19 and as long as the citizens know what they're
20 buying. But, right now, nobody knows. You know,
21 it has been lost. And so, anyway . . .

22 DR. LAUFER: I don't know if the
23 mike is on. Can you hear me?

24 I agree with what both of you guys
25 said. I think you know this is, I hope, a short

1 tenure for me. My wife told me to keep my mouth
2 shut and get out of it, is what she said. So,
3 anyway -- you know, and I'm eating three days of
4 overhead and not getting income, and one of my
5 partners is in the hospital with a bypass surgery;
6 so I don't want to be here.

7 But I think I'm idealistic about
8 this. And I wonder about sort of what direction
9 we're going, because it seems like if we
10 continue -- maybe this is the way you're supposed
11 to plod along, but we'll finish the year with
12 another report that says we're headed towards a
13 cliff, and we already know that. And the cliff
14 isn't unique to Alaska.

15 And there's a certain amount of, I
16 guess, egotism here; but if we were really going to
17 do something as a commission, we need to focus on
18 other things, like what other people heading
19 towards this cliff have already tried. I brought
20 in this latest Atul Gawande article, if you guys
21 haven't read it, from the New Yorker, January 24th.

22 But I would love to start looking
23 for solutions. And there are people trying, and we
24 could hire them to come talk to us or ask them or
25 look around. We're a unique, small environment,

1 and we could do something. You know, I don't know.
2 What are the characteristics of commissions that
3 actually accomplish something?

4 REPRESENTATIVE KELLER: I guess I
5 don't have an adequate answer to that, but I think,
6 like I implied earlier, it has to do with the
7 credibility of the commission. We have a leg up
8 there, you know. The expertise around this table is
9 fantastic, and your reputations are sterling, as far
10 as I know. I've never -- you know, I haven't heard
11 anything negative. So that's part of it.

12 And, like I say, I just go back to
13 my initial points. We have to be brutally honest
14 with one another and talk about things that make us
15 uncomfortable and maybe even make recommendations
16 that are -- seem like heresy, you know. If it came
17 out of this group, then it would get some traction.
18 You know, if I come up with something as a past
19 homebuilder, pilot, whatever, it only carries a
20 little bit of weight. But if this group comes up
21 with something, it's going to be weighed more
22 heavily. So there are -- we have assets, I guess,
23 as a commission.

24 DR. LAUFER: I think no matter what
25 happens, whether we're successful or do anything, or

1 the whole thing collapses, the future is going to
2 look radically different; and I think everybody
3 knows that. And I'd like to see one where I can do
4 a better job than I do for the patients I have and
5 more people get care. I mean, we have a choice. We
6 have -- we're not at the front of the train going
7 off the cliff. Maybe we could uncouple ourselves.

8 COL. FRIEDRICHS: Yeah. Good
9 point.

10 CHAIRMAN HURLBURT: Okay. Thank
11 you so much, and thank you for being willing to have
12 us put you on the spot like that. But I think
13 that's helpful and probably the kind of thing we
14 want to come back to.

15 And if Senator Olson is able to
16 join us, we may want to steal out some time and
17 have him share his perspectives on that also with
18 us.

19
20 HEALTH CARE SPENDING IN ALASKA
21 PRELIMINARY REPORT
22

23 CHAIRMAN HURLBURT: I'd like to go
24 ahead. Mark Foster, with Mark Foster and Associates
25 and ISER, has been a valuable resource to the

1 commission and has done a lot of analytic work for
2 us. He has continued his work on that since we last
3 met, and Mark will be presenting to us now, looking
4 at health care spending in Alaska.

5 This work is preliminary. You do
6 not have copies in your notebook because it's still
7 preliminary. When it's done, we will be sharing
8 that with you. But we did want to get -- while
9 we're meeting today, have Mark have a chance to
10 share with us where he is. There will be some "Oh,
11 my goodness" slides, I think, that you'll see that
12 Mark will have up there.

13 So I'll turn it over to you, Mark.

14 MR. FOSTER: Thank you,
15 Mr. Chairman, members of the commission. Thank you
16 for the opportunity to speak today and go over our
17 preliminary findings.

18 This work was conducted by myself
19 and with ISER. It's an update to our 2006 research
20 summary: "Alaska's \$5 Billion Health Care Bill."
21 You have a copy of that, I believe, in your packet.
22 In addition, we've tried to supplement the
23 information beyond the update to look at cost
24 drivers in particular. The work was funded by the
25 State of Alaska.

1 It's a preview of information,
2 because we still have, quite frankly, the usual
3 challenges of not having enough public data to be
4 able to check all of our various estimates and
5 verify them; but we have sort of pieces and clues,
6 and enough to give you a sense, I think, where
7 the -- sort of the order of magnitude and the
8 direction of things and to, I think, raise what I
9 think are some of the more important issues.

10 All the accounting is based on the
11 national health expenditure accounts that CMS
12 maintains. And if you are familiar with their
13 stuff, the most recent state-by-state stuff is from
14 2004. So basically we're attempting to start with
15 2004 and bring that up to 2010. And we have a fair
16 number of gaps, but we're taking a run at it.

17 Any questions, errors, omissions,
18 comments, anything you've got, please send them to
19 mafa@gci.net so I can incorporate that into the
20 next round.

21 And the caveat: This has been
22 independently developed and doesn't necessarily
23 reflect the views of any of our clients, and I
24 think you'll see that from time to time in the
25 presentation.

1 I started with the summary
2 accounts. We review public data to the extent we
3 can, including cost reports, other than financials,
4 federal reports on funding, census bureau
5 information, all the public information we can get
6 our hand on, in addition to a number of industry
7 sources that are available for purchase -- AHA,
8 AMA, Deloitte, Ingenix, et cetera. We're
9 attempting also, in our cost driver information, to
10 look at the literature and try and understand how
11 it might apply to Alaska. And, quite frankly, with
12 the dearth of the information, there's a bit of a
13 stretch. And I do rely on your feedback to help
14 direct this as much as anything. So I really
15 encourage your participation. It is important in
16 that regard.

17 And I do want to thank the
18 commission, Dr. Hurlburt, Deborah Erickson, and
19 Commissioner Streur for their support of this work.
20 It's been very rewarding professionally to dig into
21 the details more and more and sort of see the
22 pieces, how they fit together.

23 What's included and excluded from
24 the accounts that we're looking at -- frequently
25 people ask, "Where is the border?" And the answer

1 is it's a little bit of a border that allows stuff
2 back and forth. But what we typically don't
3 include are the fitness, recreational, sports
4 things and those kinds of activities -- which, by
5 the way, recently Deloitte took a run at that just
6 earlier this month. And so if you're curious about
7 the relative magnitude, that right-hand column of
8 sports nutrition, health sort of stuff that might
9 fit into a wellness program might be about a
10 15 percent adder to the national health accounts,
11 rough order of magnitude.

12 Another thing I want to point
13 out -- on the accounting, home health care, in the
14 national accounts, includes lots of things that
15 occur at the home, and there are a variety of
16 things. When we think about Medicaid programs that
17 don't necessarily fit into health -- but the home
18 and community based waivers, for example -- and
19 they wind up getting rolled into, frequently, a
20 combination of home health and other personal
21 health care. So the accounts, if you will, don't
22 necessarily line up on programs. So there is a
23 little -- sometimes we've got to be mindful of
24 that.

25 When I think about the topics that

1 we're looking at, it's really quite a span of
2 topics. There is just the overall cost of care;
3 geographic differentials; what's driving the
4 differentials between geographies; what's driving
5 cost growth in general, regardless of where you're
6 at and which geography; and how does that split out
7 both by payer and by provider. And that's really
8 sort of the span, if you will, of topics that we're
9 attempting to capture. And given the paucity of
10 data, it's really pretty ambitious, but we're going
11 to take a run at it to try and develop just a
12 little deeper and broader understanding.

13 Cost of health care, sort of
14 Chapter 1. When we go from 2001 to 2010, and we're
15 looking at millions of nominal dollars, 2001 total
16 spend in Alaska on those expenditure accounts was
17 \$3.6, \$3.7 billion. And now we're up -- we're
18 approaching \$7.5 billion. So that's sort of the
19 big picture.

20 And when you plot it out this way,
21 you go, "Wow, everything is growing." And I think
22 the short answer is, "Yes. Everything is growing
23 when we're at this high level of detail." And it's
24 only when we dive down that we really start to see
25 the differential growth in and among the various

1 categories from hospitals, physicians, dental
2 services, on up, prescription drugs.

3 And I think you'll see some of the
4 changes in those growth patterns. You'll see just
5 sort of what look like little changes here we can
6 magnify and have a better understanding.

7 When we take that data and break
8 it out to individual services, you can see there
9 are really two big categories. Hospital care is
10 the top line. Physician and clinical services is
11 this growth line that's catching up. And you'll
12 find that's true in the national data, and we see
13 it in the data that we have here in Alaska as well,
14 is when I look at the national accounts, what we're
15 finding is the physician and clinical services over
16 time is growing a little bit faster than hospital
17 care, which has a little more cost containment. So
18 if I look at the growth curves, they're merging.

19 And it's partly an artifact of
20 what's in and what's out. Hospitals providing the
21 service doesn't necessarily mean it's hospital
22 care. Keep in mind that physicians providing
23 service within the hospital are classified within
24 physician and clinical services. And so it's
25 really a reflection of the growth in physicians

1 providing service regardless of where exactly they
2 are providing it.

3 Yes?

4 DR. LAUFER: Is this a reflection
5 of shorter admissions, perhaps?

6 MR. FOSTER: Right. We have
7 shorter lengths of stay in the hospital data. And
8 you basically see, if you will, less cost growth in
9 the hospital accounts than you do in the physician
10 accounts.

11 DR. LAUFER: Interesting.

12 MR. FOSTER: And roughly, for
13 Alaska, that gets us, in 2010, somewhere in the
14 \$2.3, \$2.4, \$2.5, in that range, billion for each of
15 those categories.

16 When we do the projections out for
17 the next ten years, I think it's useful to keep in
18 mind mostly what we're doing is we're following the
19 CMS cost driver analysis about relative medical
20 prices, economy-wide inflation -- that's
21 2.4 percent -- increase in utilization of services,
22 and the population growth and age mix.

23 And that's really what is driving
24 most of our projection differences between Alaska
25 and the U.S. We have a more rapidly growing senior

1 population; which is to say it's growing more
2 rapidly, but we're still not catching up to the
3 U.S. If I look at the percentage of the population
4 65 and older, 2010 through 2020, we're about 5
5 percentage points behind now, and we're going to
6 close that gap to about 3. And that's the
7 differential here.

8 And that differential winds up
9 looking pretty small when you look across this
10 scale, but because of the relative intensity of
11 care for the 65-and-older demographic, it really
12 does drive a lot of costs through the system; and
13 it really has a large multiplier effect, if you
14 will. And we'll see that in some follow-on slides.

15 One of those is basically
16 somewhere around 7 1/2, and the revised number that
17 we have now is getting up to about 14 1/2 in 2020,
18 recognizing that the compound annual cost growth
19 rate has declined; and we believe it will continue
20 to decline a bit going forward. And even with that
21 decline, you're still getting a pretty big number.
22 These are all nominal dollars as you go forward
23 over this time period.

24 The other graph -- the next one I
25 include, I want to include, is a reference graph,

1 because it has been distributed widely. And it
2 talks about the cost of health care as a percentage
3 of the wellhead value of oil. And I want to remind
4 people before I show it that it includes two things
5 that have changed since the last time you've seen
6 the graph.

7 One is the updated cost here of
8 health care, and the other is oil revenue
9 projections have changed from the prior time. And
10 the oil revenue projections have changed upward as
11 well. So both of those have moved in concert, and
12 so we're still looking at basically in the
13 70 percent range when we get to 2020 with, you
14 know, a slight differential based on our estimates
15 on the PPACA.

16 Some important take-aways: I want
17 to look at sort of long term 2001-2020 shares of
18 the health care spend. I need to redo this slide,
19 but I'll give you the important take-aways.

20 Private health insurance covers a
21 certain amount of that total spend, Medicare,
22 Medicaid. The new insurance exchange will show up
23 on the next slide. Third-party payers, public
24 health, out-of-pocket. I think the important
25 things to take away are we see evidence that as

1 Medicaid changes -- it grows and then shrinks as a
2 percentage of the total care -- we see an offset in
3 private health insurance. We do see some
4 back-and-forth movement there, and a little bit in
5 out-of-pocket, but not as much as you might expect.
6 We really do -- in the limited data that we do
7 have, it does look like there are, if you will,
8 people on the margin who go in and out of Medicaid
9 and private insurance, self-pay, small groups,
10 large groups. There is just that churn back and
11 forth, and so we do tend to see that.

12 Medicare -- we see the demographic
13 growth, but it's -- you'll see just a small
14 share -- you get up to 10 percent. You start at
15 7 percent -- partly because you've got Medicare
16 cost containment and relatively low reimbursements
17 containing what otherwise would be rapid growth if
18 it was reflecting, if you will, the cost that we
19 see there. And so I think some of that cost, if
20 you will, is getting shifted out and getting paid
21 for by private insurance.

22 I think the other important
23 take-away when we look at the total is the
24 out-of-pocket tends to get smaller as a percentage
25 of the total spend, but it's still growing rapidly,

1 because everything else is growing rapidly. But
2 it's just a slightly smaller exposure on the
3 out-of-pocket side.

4 PPACA is now on this slide, and
5 there is, basically, the new insurance exchange
6 sliver starts growing in there. And you might get
7 to, say, 3, 4 percent. It takes some away from
8 here. There is a little bit of cost containment,
9 PPAC, that puts a little brake on Medicare. And
10 you'll notice it takes a little more out of the
11 out-of-pocket. The free preventive care and some
12 of the other coverage mandates basically take money
13 out of out-of-pocket and put it into subsidies of
14 various forms, Medicaid expansion and the exchange.

15 Yes?

16 MR. MORGAN: Can I ask a couple of
17 very simple questions?

18 MR. FOSTER: Sure.

19 MR. MORGAN: I guess the first
20 question was a previous slide. Could the group that
21 basically goes between private pay, private
22 insurance, and Medicaid, is that mainly the group
23 that the commissioner described as the 85 percent
24 that basically consumes about 25 percent of Medicaid
25 dollars? They are sort of in and out, depending on

1 employment opportunities or what's going on. Or do
2 we not know?

3 MR. FOSTER: I don't have
4 sufficient information to have an insightful comment
5 on that. I can't -- I don't think I know enough to
6 help you there.

7 MR. MORGAN: Okay. I like the
8 slide, though.

9 The other thing is, when you go to
10 the next slide and talk about the health insurance
11 exchange, I was reading about one of the
12 underestimates is once -- running the assumption
13 that the legislation goes through -- that you're
14 going to have what they call "out of woodwork."
15 And I don't think -- I don't think we really know
16 how many are going to come out of the woodwork yet,
17 or is that a misconception on my part?

18 MR. FOSTER: I think it's certainly
19 accurate to say we don't know. I do think we have
20 enough information we can begin to bound the problem
21 and get sort of a low and a high end. Recognizing
22 our ability to do that should be tempered by the
23 recent experience with the high-risk pools and the
24 enrollments there and our anticipation and what has
25 actually occurred.

1 So with that caveat, recognizing
2 we could be wrong by a lot, I believe we are moving
3 toward bounding how many people might show up in
4 the exchange partly because now we're getting
5 enough information from what I'll call the
6 Massachusetts experiment and enough data that I can
7 compare that data to stuff we're getting in Oregon
8 from their Medicaid control expansion and start to
9 understand what is moving some of those
10 demographics and some of those markets, and how
11 fast and how far they might be willing to move into
12 the exchange.

13 MR. MORGAN: I guess the last
14 question is -- and I'm not familiar with those
15 programs on this issue. But I don't know what type
16 of penalty they have in those states if you don't
17 sign up.

18 The federal legislation is
19 different in that theoretically, depending on court
20 cases, there's penalties if you don't sign up. And
21 we don't -- as we used to say back in Kentucky, you
22 don't know what's driving the horses over the fence
23 until you know what the penalty is.

24 MR. FOSTER: Right. And we're
25 trying to develop the estimates both with and

1 without the penalties, also keeping in mind the
2 penalties in the bill are relatively modest. In our
3 initial estimates, including those penalties and
4 then estimates without them, the differential isn't
5 all that great when you really get down to how many
6 do we think are going to move back and forth into
7 the exchange as a result of what are relatively
8 modest penalties, compared to the overall sort of
9 cost and value proposition in certain segments that
10 are -- where it's attractive.

11 MR. MORGAN: Thank you.

12 MR. FOSTER: You're welcome.

13 So if we're looking -- keeping in
14 mind we are at about a \$14.4 billion total spend in
15 2020, the differentials on the Medicaid expansion,
16 the new insurance exchanges, and then
17 out-of-pocket, Medicare, and employer-sponsored
18 health insurance, in terms of nominal dollars for
19 Alaska, are down in the range here, say
20 \$300 million, \$400 million range. And
21 employer-sponsored health care -- they'll probably,
22 if you will, see migration here and migration here,
23 and that will drop by somewhere on the order of
24 \$200 million nominal dollars.

25 I like this slide. A lot of other

1 people think it's way too busy. It tells me a lot
2 about the demographics today, what their insurance
3 coverage is in surveys, and the relative size of
4 these groups within Alaska in terms of population,
5 and then what are the demographic changes that we
6 anticipate over the next ten years in terms of the
7 size.

8 And so what we really do see in
9 the projections is there is a growth in the young
10 population. There is a decline across this
11 mid-range, and then a whole bunch of people showing
12 up in the 65-and-older range on our straight line
13 projections. Recognizing there is a fair amount of
14 uncertainty in them, it gives us a baseline to
15 start thinking about, you know, where, if you will,
16 the people are who don't have coverage and how
17 those markets might change.

18 And also recognizing that the rate
19 banding in particular suggests to me that the
20 attractive places for new insurance offerings are
21 going to be right in here, relative to the current
22 market; which is to say it's the age group right
23 before 65, sort of the 50-to-65 range, might be
24 slightly better off than they would have been
25 otherwise.

1 A couple of take-aways: When we
2 look at that same data split into male and female
3 demographics, same age groups. And I'm looking at
4 insurance coverage -- your employer, somebody
5 else's employer. And you'll note among the male
6 demographic and the female demographic, you still
7 have a lot of women to men across -- relying on
8 someone else's employment, across the age groups.
9 It really doesn't cluster in any one age group.

10 Young males are slow to enroll.
11 They're just not in a hurry to get insurance. You
12 still see the youth demographic here slower to
13 enroll, but they are starting to get up into the
14 enrollment.

15 And the military coverage is
16 particularly significant among the retirees.
17 You'll see the male military coverage right here;
18 and comparing it to other demographic blocks, it's
19 a pretty big chunk in the Alaskan market and
20 certainly much larger than other markets.

21 Health insurance. All right.
22 We're updating now the 2009 Medical Expenditure
23 Panel survey data. Looking at private sector
24 firms, the premiums they report in surveys, the
25 U.S. is in the blue, and you'll see here is the

1 dollar amounts and Alaska in the red. For single
2 coverage, we're running about 30 percent above, and
3 family coverage running about 9 percent, 10 percent
4 above.

5 Now, a couple of things to
6 remember: It's not just the price differential,
7 but what we haven't done is adjust these for the
8 actuarial values in the different markets. And I
9 don't know how significant that may be, but I do
10 raise it. When I'm down in the weeds, trying to
11 figure out how the markets might change as a result
12 of reform, one of the key questions is just how
13 valuable a particular insurance offering is in
14 terms of how much it covers versus how much
15 out-of-pocket exposure you have. And we don't
16 have, I think, enough detail to really understand
17 how those market changes are going to occur in
18 Alaska.

19 The other thing I want to note is
20 that when I look at other private sector insurance
21 surveys, they don't necessarily match up to the
22 MEPS days, which is publicly available. So I want
23 to emphasize the measurement error, if you will, in
24 these surveys is significant enough that you don't
25 want to take this to the bank; but it, I think, is

1 indicative of sort of the direction and the
2 magnitude.

3 The share of premiums that are
4 allocated to employees by private sector employers
5 in Alaska and in Washington, and single coverage:
6 Alaska now allocates more, as a percentage of that
7 premium, to the single coverage employees than they
8 do in Washington state. And they allocate more now
9 than Washington on family coverage.

10 The important take-away -- and I
11 haven't figured out how to present it quite yet --
12 is that when we looked at the 2003 data, Alaska was
13 behind other markets in allocating health care
14 costs to their employees. Now we are ahead.

15 We have -- essentially, Alaskan
16 firms have said, "This is getting too expensive,
17 and we're going to shift more costs to the
18 employees," and Alaskan firms have shifted more
19 costs faster than other states when I look at
20 Washington and Oregon. I show Washington here and
21 the U.S. average. So it's clear that there's been
22 a reaction in this market that's been faster than
23 other places at shifting costs from the employer to
24 the employee.

25 And we see little bit also -- not

1 only in the proportion, but who is offering
2 coverage -- and I'm going to look at the 2003 MEPS
3 data and 2009 MEPS data. So if I'm looking at
4 small employers in Alaska in 2003, 35 percent were
5 offering insurance. In 2009, 26 percent are
6 offering insurance; so, you know, almost 10
7 percentage points in that market share has been
8 shifted to "We're no longer offering health
9 insurance."

10 And if I benchmark that against
11 Washington state, where there is only 4 percent,
12 you can see it's a more rapid shift away from
13 offers insurance, in addition to those who do offer
14 are shifting more cost to the employees.

15 Not a lot of difference when I get
16 to the large employers; sort of the same
17 differentials maintained over the time period. So
18 really the rapid action is down here in the small
19 employers moving away from what they perceive to be
20 pretty expensive care -- or health insurance,
21 excuse me.

22 In the old ISER report, you'll
23 notice we have a section about, "Is health care
24 worth it?" and some discussions there. And a
25 couple of bullet points I think to keep in mind if

1 you look at this at a very high level, from an
2 economic, econometric analysis point of view:
3 Medical care is a pretty significant contributor to
4 health on the margin, if I'm looking down very
5 close. But the marginal effect is relatively small
6 compared to other things that tend to be lifestyle
7 oriented.

8 We continue to see that across a
9 lot of the data. It's sort of the socioeconomic
10 status and lifestyle. And increasingly we're also
11 seeing in the research poverty, especially, you
12 know, during pregnancy, and in the early years tend
13 to be significant burdens that carry through the
14 population across their entire lifespan. And so
15 you have that factor as well to keep in mind.

16 Now, on the plus side, on the
17 medical improvement side, I think there has been
18 some very good evidence, if we look at some longer
19 decade-to-decade stuff, that we've done remarkable
20 things in low-weight-infant care and in
21 cardiovascular care on the medical side.

22 Certainly it has cost some money,
23 but we've made some major improvements in who we
24 can save and really provide a life to, and I think
25 it's really quite an accomplishment. When you look

1 at it in sort of the broad context, from
2 decade-to-decade information, you really do see
3 some savings there.

4 On the other side of that, when
5 you look at the old Utah versus Nevada lifestyle
6 comparisons that show up in the literature in the
7 '70s and even, in some cases, before that and then
8 across the decades, there is an excess death rate,
9 if you will, between Nevada and Utah that is
10 frequently attributed to lifestyle. And it has
11 been running at somewhere around 30 to 40 percent.
12 It's basically deaths per 100,000, that rate. The
13 difference between Nevada and Utah continues to
14 persist across decades.

15 And so it's one of the, if you
16 will, touchstones that the health care economists
17 use to say, you know, how much of this might be
18 lifestyle related versus how much are we pushing on
19 medical care?

20 And so what's occurred over that
21 time period is you have a gap between the two, and
22 we've improved care for both; but there is still a
23 gap, and we frequently attribute it to lifestyle.

24 Yes?

25 DR. LAUFER: I'm confused by the

1 term "excess deaths." These are preventable or
2 premature deaths?

3 MR. FOSTER: It's simply
4 characterized as "excess," because it's a gap in the
5 data. It's a residual, when you're doing the
6 analysis, to say, "I have what looks like
7 socioeconomically relatively close populations."

8 DR. LAUFER: Right.

9 MR. FOSTER: So I'm controlling for
10 that. And I'm looking at this pair of populations
11 that look fairly similar in terms of money, income,
12 education, but they have different lifestyles when I
13 look across sort of the transience of the population
14 and some of those elements. And the difference in
15 the death rates are significant.

16 DR. LAUFER: It must be
17 premature -- I mean, death -- it's 100 percent
18 mortality, life.

19 MR. FOSTER: Yes. Right.

20 DR. LAUFER: So --

21 MR. FOSTER: But it's an
22 age-adjusted rate per group, and that's really what
23 we're looking at there.

24 DR. LAUFER: I think in the future
25 we're going to be measuring different parameters.

1 You know, are you happy with your life? Do you have
2 a nice narrative? Do you get to be the hero of your
3 life? Is it fulfilling? That's -- because this is,
4 I mean -- sorry.

5 MR. FOSTER: I think that's a good
6 point. The challenge, of course, is we manage what
7 we can measure, and we can measure the death rates
8 on an age-adjusted basis.

9 DR. LAUFER: Yeah.

10 MR. FOSTER: And so that's
11 frequently what we look at, but there are other
12 measures that are probably very important but maybe
13 more challenging to capture.

14 DR. LAUFER: Right. Thank you,
15 Mark.

16 MR. FOSTER: Yeah.

17 DR. LAUFER: Sorry.

18 MR. FOSTER: No, no. It's quite
19 all right.

20 We're working on the Alaska
21 development of similar stuff, but I have to say the
22 results in Alaska do look very sensitive to time
23 intervals; and we'll see that in some of the data
24 following up here, the preliminary stuff that we
25 have. Let's go back. That's not an important one.

1 When I look at the changes in
2 health determinants and outcomes between Alaska and
3 the U.S. -- and I'm looking at 1990 data and 2010
4 data. So, for example, the U.S. in 1990 and Alaska
5 in 1990, infectious disease rates per 100,000, and
6 then I come forward to 2010. Here is the U.S. and
7 here's Alaska. We have a great public health story
8 to tell in Alaska over that time period.

9 Infant mortality -- we have a
10 story to tell. Basically we're staying with, if
11 you will, the standard of care in other places, if
12 we're looking at that. And we've gone from being
13 slightly higher to basically hanging in with the
14 standard.

15 Smoking prevalence has declined.
16 We're still a little high.

17 Obesity, interestingly enough,
18 is -- we've gone from being ahead and having too
19 many obese, to being slightly behind. So we're
20 making some incremental improvements relative to
21 the U.S. population. We're growing but not as
22 fast.

23 Occupational fatalities, as you're
24 well aware, gets us on television, but we do have a
25 decline and we're making progress there. But I'll

1 note that our progress is no greater than the U.S.
2 progress in terms of the relative advantage.

3 Changes in health outcomes over
4 time: A similar presentation. We've got 1990
5 U.S., 1990 Alaska, and the 2010 U.S. and the 2010
6 Alaska. So, basically, the relative improvements
7 in medical care, getting at heart disease per
8 100,000, it looks like we're staying on pace with
9 the country. And deaths from cancer were basically
10 pretty close to staying on pace. This clearly is a
11 challenging area to make significant differences in
12 over time.

13 Yes?

14 MS. ENNIS: Is this chart adjusted
15 for age?

16 MR. FOSTER: Yes, it's
17 age-adjusted.

18 MS. ENNIS: Thank you.

19 MR. FOSTER: Yes.

20 Looking at some health
21 determinants and preventable hospitalizations with
22 our 2010 data that's age-adjusted, looking at the
23 U.S. and Alaska, preventable hospitalizations in
24 Alaska -- I'm looking at the Medicare enrollee
25 population -- Alaska leads the country. High

1 cholesterol, we're doing a little bit better; high
2 blood pressure, we're doing a little bit better;
3 and diabetes, we're doing a little bit better when
4 I look at the total population.

5 When I segment the population out,
6 there are clearly some populations that have more
7 challenges than others; but when I look at the
8 aggregate Alaska versus the aggregate U.S., you'll
9 see that, basically, after an age adjustment we're
10 still doing a little bit better than the other
11 places.

12 Geographic cost differentials are
13 part of the story we looked at in the prior report
14 and updating some of that. I don't have
15 adjustments here, but I did want to show you the
16 raw data on geographic rate differentials. When I
17 look at total health care cost per capita, U.S.
18 versus Alaska, Medicare dollars per enrollee, U.S.
19 versus Alaska -- keep in mind this is 2010 and it's
20 raw. It's not age-adjusted yet -- and then
21 Medicaid dollars per enrollee.

22 So that gives you a rough sense,
23 without the age adjustments, where things are at.
24 So if I do the age adjustment, we have a younger
25 demographic, so we're probably, at this point,

1 pretty close to par, maybe slightly over on the
2 Medicaid stuff, in 2010. And we'll look a little
3 bit more at that.

4 But to give you a sense, the
5 overall number I think is instructive, dollars per
6 capita. If I age-adjust, it's probably on the
7 order of a 30 percent differential total spend.
8 It's in that range.

9 Okay. Now, if I look at hospital
10 costs per inpatient day, the raw data, just to give
11 you a sense, shows it at about a 1.56 differential
12 in 2009 using the Ingenix data, based on the
13 Medicare cost reports, median value. It's not an
14 average, but a median value. So you've got that.
15 You've picked the middle one out of the group, is
16 what they've got. And then if we adjust for the
17 case mix and the wage index, we see the
18 differential drops to about a 1.25.

19 I just want you to keep in mind,
20 this data I think has some limited application,
21 because it really is sort of picking a median out
22 of a relatively small sample, so we're looking for
23 other ways to characterize this data that we think
24 are a little bit better. But I wanted to give you
25 just a sense of some of the challenges you have

1 when you are trying to look through what publicly
2 available data you have and how you might use it.

3 Physician procedures -- probably a
4 familiar one. We've used it before in our Medicare
5 work. And now we're looking at the 2011 fee
6 analyzer, sort of estimating U.S. versus Alaska
7 Medicare rates for a basic E&M visit, evaluation
8 and management codes. And then if I look at the
9 50th percentile private and 75th percentile
10 private, you can see the differentials between
11 Alaska and the U.S. and the differentials between
12 private payers and Medicare.

13 Now, if I move up into some common
14 specialists stuff, the radiation treatment session
15 code, for example, is a very prominent code in
16 terms of the volume of these procedures that you
17 see in both Alaska and the U.S. And you can see
18 the differential between Medicare 50th percentile
19 and 75th percentile for that particular procedure
20 in the U.S. and Alaska.

21 Another common procedure in the
22 data basically is knee surgery. And you'll see the
23 Medicare in the 50th and 75th percentile, U.S. and
24 Alaska. So you can see that the differentials are
25 pretty big between Medicare and the private sector,

1 private payers, particularly the 75th percentile.
2 And the ratios run from about two-to-one up to
3 about four-and-a-half-to-one. Maybe even some are
4 five, five-and-a-half-to-one. And, of course, the
5 Alaska differentials that we're seeing are pretty
6 big as well on those specialist procedures.

7 Intracoronary stents -- sort of a
8 similar profile; not quite as dramatic as the knee
9 surgery but still substantial.

10 Switching to prescription drugs,
11 we looked at prescription drugs in our prior
12 report. We had 2003 data. Prescriptions per
13 capita in the U.S. is 10.7. Alaska was 6.3. The
14 average price per script, a slight premium in
15 Alaska over the U.S. And so in the average cost
16 per capita for the total population for
17 prescription drugs in 2003, the U.S. was ahead of
18 Alaska.

19 In 2009, you'll see there is
20 growth in the number of scripts in the U.S. -- not
21 much growth here, but the average price is
22 continuing to increase. So if I look at the
23 differentials, not much change for Alaska on the
24 number of scripts compared to the U.S., but our
25 price per is going up a fair amount. And so our

1 average cost per capita -- our delta is about the
2 same, as it turns out.

3 Yes?

4 CHAIRMAN HURLBURT: As you continue
5 to work this, are you able to age-band that, since
6 our senior population is still low and that's when
7 the number of scripts per year just skyrockets?

8 MR. FOSTER: The short answer is I
9 don't know whether I have enough data to accurately
10 age-band it on prescription drugs in particular,
11 because of the nature of the survey data that we do
12 have on it. I might be able to get at it through
13 some other angles, but not in the particular data
14 that we have. But, yeah, that would clearly be of
15 great interest as we're looking forward.

16 But I guess I do want to note that
17 even though we've had a fair amount of growth in
18 the senior population, even though it's relatively
19 small, I sure don't see much here. The action I
20 see is in that price. So, going forward, it will
21 be very interesting to see how much the market
22 adjusts to more scripts or the average price per
23 script as you get more seniors.

24 CHAIRMAN HURLBURT: It's
25 interesting that where we have a younger

1 population -- just the general experience is you
2 have much more potential for the use of generic
3 drugs in the younger folks. The branded drugs are
4 what you are more apt to have with the seniors. So
5 if that observation is a valid statement of what
6 reality is, then it even makes the differential more
7 dramatic, you know, since our folks are younger.

8 MR. FOSTER: Yes. Let me make a
9 note of that real quick. Thank you.

10 Several sectors: Personal care,
11 the home health, which includes the waiver within
12 Medicaid; and nursing care facilities are still
13 under development. Partly there are a lot of data
14 limitations. We don't get as much rich data when
15 we're looking at personal care and stuff that's
16 going on at the home, regardless of who is
17 providing it. And so I think it makes it a little
18 more challenging to try and understand what's going
19 on in those markets, compared to, say, the data
20 that we have for hospitals or physicians, which is
21 just a richer data set at this point. You have
22 more trend data. It's deeper.

23 And so the challenge I think we
24 face is: How do we get further into the data so we
25 can see what's really driving, within each of these

1 areas, the case mix, utilization, the intensity of
2 care, and sort of segment out how much is due to
3 medical inflation and just basic inflation, so we
4 just have a better understanding of what's going on
5 there. And so we encourage all of your efforts to
6 get more data into the mix so we can get a better
7 understanding of what's going on.

8 Yes?

9 MR. MORGAN: I did get a notice.
10 We have three of the four waiver programs where I'm
11 employed. We did get a notice that we're going to,
12 starting this year, from the commission -- or from
13 the commissioner's office, that we will start filing
14 detailed cost, basically everything you described
15 there. So you may not have it now; but I think,
16 starting next year, at least with the majority of
17 the programs, you should have it.

18 And I wanted to clarify -- I was
19 watching our transcriptionist here. I wanted to
20 clarify something, because I think I misspoke when
21 I asked a question.

22 The individuals that are going
23 between the three payer types out of Medicaid, it's
24 basically the 15 percent of Medicaid -- or the
25 85 percent of the Medicaid that's utilizing

1 25 percent of the Medicaid dollars. I might have
2 misspoke, but I wanted to make that very clear.

3 So the bad news is we still have
4 this one data set we might want to look at, which I
5 don't know how you're going to do it, personally.
6 And the other one is, I think you will have that
7 data next year, at least. That doesn't help you
8 now, but --

9 MR. FOSTER: Well, I appreciate any
10 efforts to make it available, because I do think the
11 more transparency that we can have among all the
12 stakeholders, the easier it is to start talking
13 about sort of facts and really understand what's
14 going on and then go, "All right. How do we make
15 some changes that work and bring us forward?"

16 You know, in other commercial
17 settings outside of health care, I see it again and
18 again, and I see it in health care. If we can't
19 agree on the facts, it's very hard to close deals.

20 And, really, to the extent you
21 can, you want to get that baseline of sort of
22 factual information and trust, and then between
23 those two things you have an opportunity. You may
24 not be able to close the deal, but you have an
25 opportunity to do it. And I want to encourage

1 everyone to think in those terms as we think about
2 what information we've got and how we can build
3 trust in order to move forward and sort of
4 understand what changes might make some sense in
5 our particular markets.

6 Okay. Geographic cost
7 differential drivers in Alaska. Partly what we
8 have are wage and benefit premiums. If I look at
9 hospitals and physicians, from low to high, in
10 terms of salaries per FTE, and then how much output
11 do I get per FTE or how much coverage do they have,
12 here's -- you know, how many work relative value
13 units do you get out of a particular physician?
14 Are they part-time? Are they full-time plus,
15 really working hard and, you know, extending
16 themselves over a large patient panel? We've got a
17 few of those in Anchorage, and we have a few of
18 these, and some in between.

19 You know, in FTE's per occupied
20 bed, we tend to have larger numbers in Alaska, when
21 you look at the data. And then you go, "Well, why
22 is that? Why do we have more sort of people per
23 occupied bed?" And the answer winds up being
24 because, ultimately, we have more capacity in place
25 to serve those populations that show up. And

1 particularly in the smaller communities, you just
2 tend to have more spare capacity.

3 And then that capacity is in
4 place, and then when the people do show up, then
5 the FTE's get loaded on to that, and so you have
6 the relatively higher numbers. And so we see that
7 across the data. So the challenge we face across
8 all this sort of analysis is: How much capacity
9 makes sense in our particular markets? And that is
10 not a trivial question to answer, as we know from
11 Certificate of Need proceedings, among other
12 things.

13 And so that's the nut, and I think
14 the more sort of light we can shine on that and the
15 more longitudinal data we can put together, looking
16 at Certificate of Need filings and then comparing
17 actual results to the projections that were made,
18 then you can start to go, "All right. What are we
19 learning about capacity and its implications for
20 cost and access and ultimately quality in our
21 market: And I don't see a lot of that data sort of
22 being -- coming out yet.

23 Yes?

24 COL. FRIEDRICHS: Mark, I apologize
25 for having to miss part of your presentation. If

1 you touched on this, I do apologize.

2 One of the things as a hospital
3 CEO that we see on the federal side is that we keep
4 people in the hospital because the rehab step-down
5 long term care that they need is not in existence.
6 Not that it's limited; it's just not here.

7 And as you are presenting this
8 data set, is that factored in, or is this solely
9 looking at acute hospital admissions without
10 factoring in whether some of those were pending
11 transfer that could have gone to a rehab facility?

12 MR. FOSTER: Yeah. We see that in
13 the aggregate length-of-stay data in Alaska compared
14 to other places, but we haven't decomposed it into
15 each of those factors. But you definitely see it in
16 the aggregate data, the length of stay.

17 Over time, we've been slightly
18 ahead. And, you know, as length of stays have come
19 down, we still have that gap in the Alaska data.

20 A few of you have seen this
21 before --

22 COL. FRIEDRICHS: I'm sorry, Mark.
23 And so, you know, as we think through this, then, I
24 want to make sure I'm taking the right conclusion
25 from what you're saying. So the data that you're

1 presenting is that there is a gap in length of stay,
2 but can't clarify, or we can clarify, whether that
3 is due to the absence of nonacute care, rehab, or
4 step-down type facilities?

5 MR. FOSTER: I certainly have heard
6 anecdotal evidence prior to the stuff you shared. I
7 don't have sufficient data to be able to really lay
8 that out and go, "Here's how big or small that
9 problem is in terms of relative order of magnitude."

10 And if it's a priority, of course,
11 we can put it on the top of the list and try and
12 chase that down.

13 COL. FRIEDRICHS: Well, where --

14 MR. FOSTER: But we haven't drilled
15 down that far in this particular scope, is the other
16 thing to be mindful of.

17 COL. FRIEDRICHS: And where I'm
18 going with that is I think the point that you made
19 earlier is probably one of the most profound things
20 that I've heard in this whole commission discussion,
21 is we don't have data to make data-decisions. We
22 have a lot of data. It's not necessarily the right
23 data, it's not complete data, it's not comparative
24 data to make good, data-driven recommendations or
25 decisions at the legislative level.

1 And so what I would ask for your
2 help with, as you parse through this, if the
3 commission members agree, is if you can help us
4 highlight the data shortfalls.

5 One of the things that I think we
6 had tried to do, Deb -- wherever you are -- in the
7 last meeting was recommendations or observations
8 of, you know, these are things that the Health Care
9 Commission -- the constraints, if you will -- that
10 make it difficult for us to give the Legislature or
11 the Governor solid recommendations right now. And
12 until these are addressed, we'll continue to be
13 giving our anecdotal recommendation but not
14 necessarily data driven.

15 And so if there is a way to
16 continue to tease that out, this is one in
17 particular I'm very familiar with, because I know
18 that we keep people -- I get the report every
19 morning of who is sitting in a bed in the hospital
20 because they can't go to rehab because there is no
21 rehab to go to. But there are many others like
22 that that you touched on earlier in your
23 presentation.

24 MR. FOSTER: Thank you.

25 MR. CAMPBELL: Mark?

1 MR. FOSTER: Yes?

2 MR. CAMPBELL: You talked about
3 excess capacity, or seeming excess capacity. Does
4 that seem to be driving additional utilization, or
5 can you tell, inasmuch as the small communities?

6 MR. FOSTER: I've taken --

7 MR. CAMPBELL: I think I heard you
8 say that.

9 MR. FOSTER: I've taken a look --
10 but I would have to call it a fairly shallow look --
11 through the data, particularly in view of the
12 Dartmouth Atlas of Health stuff that's been brought
13 out, talking about capacity driving cost.

14 I don't see, in the data that I've
15 looked at, in the Alaska market, the capacity
16 driving higher utilization. And we are going to
17 look at that here in this next slide and talk a
18 little bit about it and why the data may be the
19 limitation, rather than the phenomenon.

20 CHAIRMAN HURLBURT: Does your data
21 show a relatively low hospital admission rate for
22 Alaska compared to the U.S.? There was a chart that
23 just came out in the most recent issue of Health
24 Leaders magazine which put us about the third lowest
25 in the country in terms of a non-age-adjusted

1 hospital admission rate.

2 MR. FOSTER: Yeah.

3 COL. FRIEDRICH: That's not the
4 federal data. That's not what the federal data
5 would suggest, so it may be --

6 CHAIRMAN HURLBURT: It may not even
7 have included federal hospitals. It didn't specify.

8 DR. LAUFER: Can I just clarify?
9 In a small community, the issue is not utilization;
10 it's that you have doctor, facility, CT scanner
11 sitting idle, and you still have to pay them. And
12 that's actually one of the appeals of a small
13 community for a small doc is I'll go there, and I'll
14 be there, and -- I used to know the doc in Seldovia.
15 And he was skiing. He was telemarking, and he had a
16 phone. And he'd say, "Oh, yeah. Okay. I'll be
17 down in an hour." But if that is salaried, he's
18 still -- you know, he's not providing any care, but
19 he's underutilized.

20 MR. FOSTER: Exactly. And the
21 phenomenon, as it turns out, when I'm looking
22 across, if you will, referral patterns and patient
23 flow in other venues, outside of the scope of this
24 work, that phenomenon occurs throughout the system
25 relative to other states.

1 And so we tend to have more
2 capacity, even within the Anchorage bowl, sort of
3 ready, willing, and able to help, depending on this
4 intermittent population showing up. Some of it is
5 seasonal, some of it is disease-driven in the
6 winter. And so all those things really create, if
7 you will, high sort of spikes in the need. And so
8 it's not unusual to see the system designed for the
9 peak requirement, because we're not putting a whole
10 bunch of people on a plane if we don't have enough
11 beds. We really have designed more capacity
12 locally, so we have local access. I think that's
13 one of the phenomena that you see when you dive
14 into the data.

15 DR. LAUFER: That actually is -- I
16 think in Anchorage, at least -- one of the few
17 examples of it actually acting like a free market,
18 in that the capacity for rheumatology -- there are
19 two private rheumatologists in town. The elder one
20 can't retire because, you know, who will people see.
21 Orthopedics, there are a lot, because of the numbers
22 up here. And, you know --

23 MR. FOSTER: So is that an
24 invitation to drill down into orthopedics?

25 DR. LAUFER: No, it is not,

1 absolutely. You know, this is a 50,000-foot view.

2 MR. FOSTER: Exactly.

3 DR. LAUFER: It's not a 50,000-foot
4 problem.

5 MR. FOSTER: When you -- let me
6 move on, before I get caught doing a bunch of data
7 drilling.

8 High-level Medicare spending, cost
9 per enrollee and cost growth over time, age
10 adjusted. Here is the compound annual growth rate
11 from '96 to 2006 by -- and we're looking at all the
12 states, and we're in fact drilling down and looking
13 at referral regions, and the Medicare spending per
14 enrollee.

15 Alaska is here in the low-cost and
16 low-cost-growth quadrant for Medicare -- admittedly
17 an administered program that tries to control
18 prices to some extent. And McAllen, Texas, that
19 you have heard about is up here. Hawaii has the
20 pole position.

21 So when I presented this to a
22 group of people in the hospital and physician
23 sectors, they looked at it, and they were a little
24 surprised that we were low-cost, low-cost-growth
25 even within Medicare, age-adjusted. And one of the

1 things they suggested to me is this may reflect, if
2 you will, just a fundamental lag we have in our
3 system here in terms of bringing the U.S. standard
4 of specialty care to Alaska.

5 We're sort of lagging behind; and,
6 as a result, we're not throwing as much of the
7 current sort of practice at the Medicare
8 population, and that's partly what we're seeing.
9 And even though we're trying to catch up and the
10 cost growth is low, that may change as that
11 population gets bigger and more, if you will,
12 specialty care says, "There may be an opportunity,
13 depending on that Medicare reimbursement rate, to
14 address that market." So we may see some movement.

15 I've heard a few other sort of
16 stories about how that might be, so I'll be real
17 curious to see the trend data when I adjust that
18 2010 raw data and get it age-adjusted to see what
19 migration might be going on in this data. So I'll
20 have essentially this plot and then arrows to show
21 where people are moving, going forward, to get a
22 feel for what's happening in the last few years.

23 Yes?

24 MS. ENNIS: Could this be
25 attributed at all to the number of physicians who

1 are declining acceptance of Medicare patients?

2 MR. FOSTER: It could. We see a
3 little bit of migration into emergency rooms; but
4 the other thing that we're seeing is a fair amount
5 of migration to what I'll call specialists providing
6 the intake and sort of a primary care screening by a
7 nurse practitioner, for example. And there is
8 almost a bypass, if you will, of the primary care
9 physician, going right to the specialist, because
10 the reimbursements for the specialist look
11 attractive.

12 But that's only occurred within
13 the last few years. Keep in mind, here we are at
14 2006 data. The Medicare bump-up in reimbursements
15 was 2004-2005, and then it dropped back off. So
16 we're really -- the snapshot may not be really
17 instructive to where we're at today.

18 MS. ENNIS: Thank you.

19 MR. FOSTER: Now, Medicaid
20 spending -- and I've got two axes here, one for the
21 U.S. and one for Alaska, millions of nominal
22 dollars, 1997 through 2009. And you can see the
23 Alaska growth and then leveling and then an uptick
24 here into 2009 that continues into 2010; and then
25 the U.S. sort of baseline data, if you will. So you

1 can see the relative performance on the total spend
2 side in millions of nominal dollars.

3 Now I'm going to break that down,
4 and I'm going to index Medicaid cost growth into
5 some factors based on one in 1997 and go, "What's
6 driving that top line that we just saw of total
7 cost in nominal dollars to go from 1.0 to almost
8 3.5 in 2009? What are the factors that are driving
9 that?"

10 And if I break it down into a
11 population growth, an enrollment rate, utilization
12 of services, intensity of services, and price
13 inflation, you can sort of see the breaks. And the
14 color coding isn't probably as easy for you to see,
15 so I'll point it out for you.

16 This is utilization of services.
17 That means how many services are enrollees
18 utilizing? "Do I get an x-ray or not" would count
19 as a utilization. How many I got would be
20 intensity of service. And you'll see this is the
21 intensity of service line here. The enrollment
22 rate is right there. Population growth is
23 basically that low line. So the big driver is the
24 number of services that are available and utilized.

25 Now, if I take the Medicaid

1 historic data and the projections from the MESA
2 2009 -- and this is the baseline without any PPACA
3 stuff in there -- and we look at the line here,
4 this is inpatient hospital -- these are ordered, by
5 the way, by where they stack right here, so you can
6 follow it. The waiver projection that MESA has to
7 2020 is here. Personal care projection they have
8 is here. And so you can see they're basically
9 saying we have a rapidly aging population,
10 basically a demographic driver; and we're going to
11 continue to offer, if you will, those services.
12 And that really leads to a relatively rapid growth
13 relative to the other service lines, if you will,
14 if I'm looking at that Medicaid data in the MESA
15 projections on Table 17 that's publicly available.

16 CHAIRMAN HURLBURT: This may be an
17 editorial comment, but I'm thinking I've been living
18 most of my life on the left side of the graph. As a
19 payer, you think about paying historically a little
20 more than a third for hospitals, a little less than
21 a third for clinicians, as you've shown -- and
22 that's come up -- but then about a third all other.

23 But this is the preamble to our
24 discussions tomorrow, and we'll look at that again,
25 because this is -- it just totally blows my mind,

1 based on having lived on the left end of that.

2 MR. FOSTER: Private payers -- we
3 have relatively limited data on the private payer
4 side. We're currently working with private payers
5 to try and develop some of that data. I'm quite
6 hopeful we're going to have some data to bring to
7 bear to these questions.

8 A couple of very preliminary
9 things, based on what I've seen so far -- and I
10 want to remind the folks here in sort of a sneak
11 preview of coming attractions: What I'm seeing is
12 Medicare and Medicaid may be providing below-cost
13 reimbursements and, of course, the self-paid
14 uninsured aren't paying their full weight. And the
15 result is you get a shift of hospitals, physicians,
16 other providers, to private payers in Alaska -- and
17 certainly I see it over the last decade -- a sort
18 of a shift in costs.

19 And so one of the challenges I
20 think we face is if we've got below-cost
21 reimbursements -- particularly for Medicare,
22 because it's an easy one to spot and see, and it's
23 easy to pick on somebody from Washington, D.C.
24 rather than locally -- and look at the productivity
25 adjustments that are assumed in the PPAC Medicare

1 cost containment. They raise the risk of
2 additional cost shifting to private payers.

3 And so really the question is:
4 Can we make those productivity improvements, and
5 how are we going to achieve them in this market?
6 That's our challenge. How much can we reasonably
7 expect and how will it be shared between the
8 providers? Does Medicare capture it and the others
9 are on their own, or does the system really
10 equilibrate; and, if it meets the Medicare
11 productivity improvements, everyone gets to share
12 in that?

13 The national data suggests that if
14 we're driving Medicare cost containment and we're
15 getting cost containment there, it's shared by all
16 of the other payers. That's the national data.
17 The national data is dominated by some markets that
18 are more competitive than ours. So there is a real
19 open question in my mind whether or not, if I push
20 on one side of the balloon, if you will, whether
21 that makes the whole balloon get smaller, or
22 whether you get a cost shift.

23 And I think, in our market, it's
24 preliminary, but I see more potential and more
25 evidence for cost shifting being something that can

1 really occur here relative to some other markets
2 that may have a little more competition on the
3 margin compared to what we may have here because of
4 the particular way we're organized.

5 So I think you just want to be
6 mindful of that. If you save costs in one place,
7 is it really driving system change, or is it just
8 shifting the costs around?

9 Yes?

10 DR. LAUFER: I can just say, for my
11 practice, there is definitely cost shifting.
12 It's -- we're paid way, way, way under cost for
13 Medicare. We still do it as a sense of duty to the
14 community. No one is competing for these patients.
15 The other two largest primary care clinics in
16 Anchorage do not take Medicare at all.

17 And, you know, for example, a
18 pelvic exam, Pap smear, rectal exam, hemocult, and
19 breast exam on a female Medicare patient reimburses
20 \$46. We do it at a loss. I mean, we can only
21 afford do to it for so many people, and everybody
22 else pays for that. No question. That's
23 definitely the case, and it's been the case for
24 decades.

25 MR. MORGAN: I guess here I'm

1 speaking globally. At the beginning of my career in
2 the '70s, I worked in the Lower 48 in small, rural
3 hospitals right when the DRG concept hit between
4 urban and rural hospitals. In Indiana, you really
5 couldn't cost shift very much. We had a rate review
6 system. We filed -- every hospital filed a cost
7 report just like any utility. I saw 20 percent --
8 when the rural, nonurban, DRGs went into effect,
9 hospitals under 50 beds that could not cost shift
10 and couldn't become efficient, they are no longer
11 there. In Kentucky, we had the opposite situation
12 where you could do some cost shifting, and you had a
13 little more wiggle room.

14 The interesting fact is, the
15 health care financial manager associations looked
16 at that, and in those states that had that type of
17 rate review and managed care system, they found
18 that it didn't matter how efficient you were, if
19 you had more than 50 percent Medicaid and Medicare,
20 you were basically doomed. You could not make it
21 as a small hospital under 50 beds.

22 So these kind of decisions can
23 have big effects outside of some of the other
24 systems in the state.

25 Yes?

1 MR. CAMPBELL: You talk about cost
2 shifting. I think you may have illustrated it
3 earlier, where the costs have been shifting,
4 particularly in the smaller employers, to more -- a
5 larger share to the employee. And you can highlight
6 that, I presume, and let us make some choices.

7 MR. FOSTER: Yes. There is cost
8 shifting throughout the system, both with providers,
9 employers/employees, and it's quite prevalent. So I
10 think one of the big challenges we face is, if we
11 try and attack costs at a particular point, is to
12 recognize it may just get shifted to another spot.
13 So you really just want to be mindful of those
14 boundary conditions.

15 I'm getting close to the end.
16 Thank you for your patience. Now I want to step
17 back and look at what's really driving cost growth
18 over time. What are the fundamental things that we
19 see that are the causal -- not just correlation
20 stuff, but what do we think is really the cause
21 that's driving this stuff?

22 And one cut at that is to look at
23 the percentage growth, the average annual growth in
24 real per capita health spending. And we're looking
25 across 1960 to 2007, and then we're going to make

1 some observations going forward.

2 And I'm relying here on Joe
3 Newhouse, who -- we're lucky to still have him
4 around. He was one of the Harvard economists who
5 did a lot of the work with the Rand experiment in
6 the 1970s and is, subsequently, just sort of deep
7 into the data and is doing some great analysis.

8 What are we talking about here?
9 We're really trying to understand, as you get
10 richer, how much health care do you want, as you
11 get more income? And the answer is: It's
12 somewhere in this range that for every, you know,
13 sort of dollar you get more, there is a percentage
14 that you're going to put into health.

15 And it tends to be relatively high
16 compared to other things. When we really look at
17 growth in income, we tend to buy bigger houses, we
18 tend to buy more health care, and we tend to buy
19 more education. Those are really the incremental
20 things that you see people buy as they get
21 wealthier.

22 And so one of the things we try
23 and tease out in health care is: What are the
24 income effects? And the answer is: On that cost
25 growth, if I'm looking at that cost growth as a

1 100 percent pie that I've got to divide up over
2 this time period, somewhere between, let's call it,
3 30 and 40 percent is really income-driven of that
4 total cost growth pie that we have. It's just
5 we're getting wealthier, and we want more of what
6 health provides us.

7 You've got the demographic
8 effects -- just the aging population tends to be a
9 little bit smaller than you might anticipate.
10 Price inflation -- if we assume medical care
11 productivity is zero, it might be as high as 10 to,
12 call it, 20 percent. If we assume medical
13 productivity approached the average of the economy,
14 it might be down here. The reality is, it's
15 probably in the 8 percent to 10 percent range, is
16 what price inflation is over time.

17 Demographic effects. The changes
18 in insurance coverage -- insurance, basically, if
19 you will, puts you away from first-dollar exposure
20 frequently or significant-dollar exposure, so you
21 tend to consume more. But that effect over this
22 time period, as it turns out, is only 10 percent of
23 that total pie.

24 Technology tends to be a big
25 piece, and it's both the interaction between -- if

1 we have more money, we want newer stuff. And then
2 there is just an underlying growth in science and
3 what we know about the human body and the human
4 psyche and those interactions, and we tend to want
5 to go, "We can help you, because we've learned more
6 about how this all works."

7 And that winds up being anywhere
8 from maybe a quarter to a half of what's driving
9 it. And I think the thing to keep in mind is what
10 happens is, we come up with lower treatment
11 thresholds as we learn more, is frequently a
12 phenomenon, and we also find new treatments that
13 we're bringing to bear. And the combination of
14 those two factors is probably about a third to a
15 half of what's driving health care costs.

16 And so if we're going to contain
17 costs, we just want to be mindful that's one of the
18 factors that you may have an influence on when
19 you're talking at the U.S. level, is that
20 technology curve. And ultimately how quickly we
21 can adopt access to current technology in the
22 Alaska market depends in part on reimbursements for
23 equipment, for diagnostics and other things, for
24 treatments. So that's one of the things I think
25 you'll need to be mindful of as you work your way

1 through the detail with that.

2 I think I have a question or
3 observation. Yes?

4 DR. LAUFER: How were heart attacks
5 treated in 1960? Morphine?

6 CHAIRMAN HURLBURT: Humidity,
7 oxygen, analgesia, and prayer. That's the mnemonic
8 I learned in medical school.

9 MR. LAUFER: It's a different
10 world. It costs a lot of money to keep people alive
11 for a long period of time. Humidity? Wow.

12 MR. FOSTER: Here is, I think, some
13 useful speculation to keep in mind when you're up at
14 the 50,000-foot level. The current recession will
15 reduce spending growth in the near term. Newhouse
16 thinks that the U.S. is going to be roughly
17 comparable to the managed care era of the 1990s.
18 The recession is putting a squeeze on the Lower 48,
19 and it shows in the data.

20 Over the longer term, insurance is
21 not likely to exert as large a positive effect on
22 spending as it has historically, because we're
23 already covering 85, 86, 87 percent of the
24 population, up from 45 percent in 1960. We have
25 dramatically expanded in the U.S. economy

1 insurance, and now we're talking about smaller
2 increments going forward.

3 And insurance has moved from being
4 relatively passive to being more and more active
5 over time. And the out-of-pocket spending share
6 will not fall as fast as it has in the past. Over
7 the last 50 years, out-of-pocket spending on health
8 care has gone from roughly half to about
9 10 percent. That's a large change.

10 Now the increments going forward
11 are smaller. We're talking 10, down to maybe 8,
12 you know, and sort of in that range. So the
13 effect, if you will, of having insurance is not
14 likely to be as dramatic when we are looking at it
15 from this 50,000-foot level.

16 The tension we have, ultimately,
17 is we've got income growth to drive a rising share
18 on health. As people get richer, they want more,
19 and they tend to want more health among other
20 things. And there's going to be spending on new
21 medical technologies that continues. And it looks
22 likely to continue to grow faster than incomes.

23 And ultimately, it's Newhouse's
24 observation, that that effect must diminish as the
25 opportunity cost of the additional growth in health

1 care spending rises. What percentage of our
2 overall budget can we devote to that before it
3 really starts to impinge on other areas of all
4 other goods and services? And having watched it
5 for decades, he's suggesting to us that there is a
6 real issue here that's emerging, because it's now
7 gotten big enough and our wealth isn't growing fast
8 enough to sort of keep up with it.

9 And I think that's one of the key
10 take-aways when you look at sort of this long,
11 longitudinal data, and then you dive in to try and
12 understand what's driving that cost growth.

13 Just some observations. This is
14 my last slide. Cost control efforts can appear to
15 reduce cost growth for the payer, whoever that
16 happens to be -- Medicare, for example -- but it
17 looks like it's resulting in cost shifting. So we
18 just want to be mindful of cost shifting.

19 We also want to be mindful that,
20 going forward, cost shifting might be tough as
21 income growth might decelerate relative to the
22 past, and employers are now shifting more costs to
23 employees, and you've got the employees facing
24 inflation in other high-value consumption areas.
25 The price of gasoline comes to mind.

1 We're getting into some tighter
2 squeezes than we've been in in the past. And I
3 think they look at material when I look at
4 percentage of household income that goes to these
5 various things that people are consuming or
6 investing in.

7 One of our challenges is how fast
8 can a particular local referral region and its
9 individual providers -- how fast can their
10 productivity rise to still balance the local access
11 and quality considerations while these pressures
12 come on the budget? And it's that local referral
13 region and the providers that I think are going to
14 be the ones who have to sort of go, "What can we do
15 with these sort of global pressures coming to
16 bear?"

17 And then the final take-away I
18 want to leave you with is: At some point, we've
19 got a smaller portion of workers supporting both a
20 growing younger population in Alaska and a growing
21 retirement-age population in Alaska. We face one
22 of the most difficult challenges as a state,
23 compared to other states, because we've got two
24 demographic bulges that are growing faster than
25 other states. It's both the young and the old,

1 relative to other states, and fewer workers to
2 support those dependents on both ends of the scale.

3 So I submit to you that our
4 challenge has been sort of slow and bubbling up, if
5 you will, and now it's going to accelerate. So you
6 want to be mindful of that as you think about, "All
7 right. Is this an urgent problem? It may not
8 appear urgent right now, but I suggest to you that
9 it could quickly become quite urgent as you think
10 about: How are we going to balance our local
11 access and quality considerations in our local
12 communities with, if you will, the problem of how
13 much can we afford?" It's far from a trivial
14 exercise to sort it out.

15 Thank you very much for your time.
16 I certainly appreciate the opportunity to share the
17 preliminary findings that we have from the data.

18 CHAIRMAN HURLBURT: Could we maybe
19 take a ten-minute break? We're a little bit behind.
20 And I wonder, when we get back together, Mark, would
21 it be all right with you if you go back where you're
22 sitting right now, because as we have the
23 discussion, we may want to refer back to a specific
24 slide that you had up or something?

25 MR. FOSTER: Sure.

1 CHAIRMAN HURLBURT: So we'll come
2 back and we'll discuss this whole area more. That
3 was just outstanding, Mark. Thank you very much.

4 MR. FOSTER: Thank you.

5 (Applause.)

6 10:11 AM

7 (Off record.)

8 10:36 AM

9
10 GROUP DISCUSSION

11 HEALTH CARE SPENDING IN ALASKA

12
13 CHAIRMAN HURLBURT: So the next
14 session we have is Health Care Spending in Alaska.
15 We had the report, and we now want to have the group
16 discussion. We had a fair amount of discussion
17 while Mark was presenting the data and the analyses
18 that he had to us. Deb and I have both been pushing
19 to keep us at the 50,000-foot level, that we not get
20 down into the weeds too much, but where are we
21 going? Why are we getting this?

22 And, Noah, I don't know if you
23 want to start out saying what your vision or hope
24 was, is: How are we going to use this? And kind
25 of thinking in the time frame of our next report is

1 due in January, January 15th. So we have about
2 nine and a half months now until we get there.

3 So what is your hope on that,
4 Noah?

5 DR. LAUFER: I'm sorry. My hope
6 for the commission, or for the world my children
7 live in?

8 CHAIRMAN HURLBURT: Yes. Right.

9 DR. LAUFER: No, I -- this is very
10 idealistic, and we're not alone in this. You know,
11 there is stuff going on all over the place. I was
12 just on the Internet. There is a program at
13 Columbia University in something called narrative
14 medicine, which is kind of an interesting idea. And
15 that would be when you see your primary care doc,
16 the question isn't -- it's a bigger question: "How
17 is life going? Is it going the way you want it to
18 be?"

19 You know, and that's a much bigger
20 question. It's almost a traditional healer
21 question. But I see that, actually, as the answer
22 when we measure different parameters. And what I
23 need, as a primary care doc, to do that is better
24 tools. And I would love to see us come up with
25 some really significant recommendations, rather

1 than just a reiteration of how bad things are.

2 I told you the cost for my clinic
3 for health care went up 18 percent again this year.
4 It's a huge burden and tax on us. Everybody knows
5 it's bad. I mean, that's where we're at. But when
6 we looked at what Jason Hooley told us, it isn't to
7 tell them how bad it is; it's to tell them what to
8 do or provide some recommendations.

9 And I would love to see some
10 experts come and talk to us about what they found
11 to be helpful or be pitfalls. And these are going
12 to probably be somewhat peripheral, you know,
13 radicals, because the solutions are going to come
14 from there, you know.

15 Could we measure, I was asking
16 Jeff, sort of vitality? You know, what are you
17 actually buying? Everybody is flirting with this.
18 But it's somewhere along those lines, and I'll be
19 quiet. Thanks.

20 CHAIRMAN HURLBURT: Thank you.

21 Are there some questions that
22 Mark's presentation raised?

23 Yes, Larry?

24 DR. STINSON: I was having a
25 conversation with Representative Keller, and he had

1 some specific questions about Slide 14 and 40 that
2 he wanted to -- he had to go, but he wanted me to
3 bring up in discussion. I think he probably had
4 Slide 14 wrong. It was the graph. Maybe the next
5 one.

6 He was wondering -- well, I guess,
7 in general to all of these, he was wondering if
8 there are assumptions built in that -- and
9 undoubtedly he got the slides wrong -- that the
10 government was going to pick up cost shifting if
11 the private insurance didn't do it and
12 Medicaid/Medicare weren't going to do it or were
13 not as flexible. Is their assumption that somehow
14 the state is going to chip in with Medicaid or some
15 other kind of state funding?

16 MR. FOSTER: The projections we've
17 developed have focused -- in terms of the ten-year
18 projections going out, have tended to focus on what
19 are the underlying population cost drivers.

20 So it's basically if we have got a
21 demographic change, and then we really think we've
22 got utilization, economy-wide prices, medical
23 prices, they are pretty similar to the U.S. And
24 that's our baseline projection. We've adjusted
25 that for the Medicaid projection that's publicly

1 available, and we believe that -- and then when we
2 look at the Affordable Care Act, the increments
3 there, we see Medicare reimbursement cost
4 containment pushing down, and we expect there to be
5 some cost shifting from the squeeze on Medicare to
6 go to private payers.

7 So we haven't built in any cost
8 shifting in our projections with respect to
9 Medicaid. So that's how we built it, because we
10 really haven't gone in and tried to figure out: Is
11 Medicaid going forward? Are they going to change,
12 if you will, their pricing policy to pay at cost?
13 Above? Below? And so we haven't -- you know, we
14 can generate scenarios, but we haven't looked at
15 that.

16 DR. STINSON: And I think the
17 reason why he was bringing that up is he's, of
18 course, hoping the Medicaid cost will actually
19 decrease in Alaska, what kind of pressure that would
20 put on the system.

21 And then the other slide -- which,
22 again, I don't know if he had the slide correctly.

23 MR. FOSTER: 40.

24 DR. STINSON: He said 40. That
25 wasn't the -- okay. There was another slide where

1 Medicaid came back and kind of paralleled, between
2 the state and the U.S., for the last bit, where
3 Alaska Medicaid was higher and then it kind of came
4 back in line.

5 MR. FOSTER: I think this is the
6 one.

7 DR. STINSON: Yes. It's that one.

8 MR. FOSTER: Right. We're looking
9 at total spend in millions of nominal dollars with
10 Alaska on this scale, the U.S. on this scale, so we
11 can see the relative trends over time.

12 DR. STINSON: And his question --
13 he was wondering, on the Affordable Care Act, what
14 kind of assumptions or -- I know we don't have data
15 yet, but where does that scale -- where does that go
16 from this point forward? Best guess.

17 MR. FOSTER: So where does this go?

18 DR. STINSON: Correct.

19 MR. FOSTER: The short answer is,
20 under the MESA projections that are publicly
21 produced, or the ones we've been using -- so we
22 haven't done an independent projection on that
23 piece -- they have got a schedule there that shows a
24 bump in the Medicaid expansion. It shows an
25 enrollment bump and a spending bump, and that's what

1 we've been incorporating in.

2 If you need follow-up on that, I'm
3 happy to send you the stuff I've got; but it's
4 basically the same stuff the department has, so you
5 may want to get it directly from them. And I'll
6 defer to Deb on how to best coordinate that
7 response. But I'm happy to do it, or someone else
8 can do it, but let's -- I want to make sure that
9 they get a shot at it rather than having me take a
10 cut at it.

11 CHAIRMAN HURLBURT: The
12 flattening -- yes, in that area -- was largely
13 related to a reduction in Medicaid enrollment
14 related to the state's economy. And so that was a
15 real success --

16 MR. FOSTER: Yes. Here's the
17 enrollment piece.

18 CHAIRMAN HURLBURT: -- probably
19 attributed to a success in management, but it was
20 really more a success in having a good economy and
21 less people qualifying and needing to enroll for
22 Medicaid.

23 So if what Wes is doing right
24 now -- if he and the Governor and the Senate and
25 all collectively guess right, whatever that's going

1 to be, to get more throughput through the pipeline,
2 you know, and we get more jobs, there could be a
3 flattening totally unrelated to health care. So we
4 could see that.

5 But, you know, without that, the
6 pressures are going up. Medicaid is going up, this
7 year to next year, a couple hundred million dollars
8 in Alaska total federal and state money. And I
9 think the reality is that it could well do the same
10 thing again the next year, because we are still in
11 pretty good shape.

12 But the future is what I described
13 Governor Quinn of Illinois telling his folks: "You
14 got to go for a 22 percent cut," and here is this
15 guy who is clearly a supporter of the President,
16 but talking about continuation of effort, which is
17 one of the mandates of PPACA. He says, "I don't
18 care what they say. There is no way we're going to
19 be able to continue that effort."

20 So here's the reality of
21 90 percent of the states really suffering and doing
22 that. At some point, that probably would be our
23 future too.

24 MR. MORGAN: Now that the
25 legislative guys have left, would looking at the new

1 census data for redistricting -- I noticed that
2 there was a huge shift in total census, mainly a
3 shift to the Mat-Su-Anchorage-Kenai, while the rural
4 parts of the state and Southeast lost significant
5 population.

6 I know that this is a very
7 convoluted idea, but I get them every once in a
8 while. Could that, by the population moving to
9 where competition is a little higher, could it be
10 having an effect? Or is it a butterfly landing on
11 the battleship?

12 And the other thing -- I'm going
13 to speak globally, which will make Debbie happy --
14 no matter what or who is paying it, we can move it
15 around. If the economy goes up, people get jobs,
16 get off Medicaid, they might work longer and not be
17 on Medicare, maybe. But, still, the real problem
18 of overall cost is still there, and we're going to
19 move that pea around different shells.

20 So the bad news is your wife may
21 be disappointed that you'll be spending more time,
22 but the good news for the state may be, with an
23 uptick in the economy, at least it will move off of
24 Medicaid into Jeff Davis's area or the employers'
25 area.

1 But still, no matter how we can
2 move it around, we've got a real cost problem. I
3 don't think anyone disagrees with that.

4 CHAIRMAN HURLBURT: Keith?

5 MR. CAMPBELL: Do you -- I thought
6 I saw some data about your price, the elasticity.
7 Do you sense and can you demonstrate that there is a
8 lack of pricing elasticity and what -- if that's
9 true, where you no longer are going to raise prices,
10 what does that, ultimately, do to the providers and
11 things like that?

12 MR. FOSTER: To the extent we're,
13 if you will, hitting a zone where the marginal
14 health care spending dollar is not competing with
15 other opportunities -- and I think there is some
16 evidence that's beginning to occur in Alaska and in
17 other markets. So if that's happening, and we put
18 more pressure on, I mean, what are the responses?

19 Providers become more efficient,
20 and ultimately they -- how much more efficient can
21 they become is not only sort of a short-term "How
22 many people do I have staffing, and how do I run
23 the process?"

24 Then there is the long term
25 question of, "What new technology do I keep

1 bringing to bear?" And I think that's where the
2 tension is in terms of "What's my response?"

3 First, it's people. How many
4 people do I have here to work with the particular
5 issue, and how do I organize them? And then it's
6 sort of the five-year plan. What's the new big
7 thing I'm going to buy in terms of diagnostic
8 capability and treatment capability?

9 And so I think what will happen,
10 if it's true to form, is in the short term, we'll
11 make decisions about basically staffing. And in
12 the long term, depending on the outlook, we may
13 temper our purchases of new capacity, sort of new
14 capabilities. And I think that's where the tension
15 winds up coming down.

16 There will be a lot of churn,
17 short term, about "Well, in my annual budget, I
18 can't make it." But I think the more challenging
19 question we have long term is: How much current
20 sort of practice can we bring to bear in this
21 market, and how much of it is in other markets, if
22 we need to go get it?

23 You know, I have patients who have
24 frequently gotten on a plane to go get care in
25 other places, and they could afford to. And how

1 much of that occurs I think is going to be the
2 other consideration as we go forward and these
3 pressures come to bear.

4 Does that get to some of the
5 question?

6 MR. CAMPBELL: Yes, it does. But I
7 talk about the elasticity, because we can see the
8 growth of the Medicare funding. Medicare is already
9 under great pressure. There is going to be --
10 particularly from the insurance industry, there is
11 going to be lots of pressure. So it's -- you know,
12 you squeeze that balloon, and if everybody is
13 squeezing the balloon, something has got to pop.

14 MR. FOSTER: And at some point -- I
15 think one of the illustrations in the Office of the
16 Chief Actuary from CMS, Richard Foster, in his
17 April 2010 memorandum describing the Affordable Care
18 Act and what's the implication of the cost
19 containment for Medicare, their projections estimate
20 that something like 15 percent of the providers who
21 are serving that population will be at risk of
22 bankruptcy as a result of that.

23 So, I mean, there are providers
24 who are -- you know, maybe don't have a lot of
25 margin, and what are their choices?

1 Consolidations? Going out of business? So those,
2 I think, are some of the kinds of pressures that
3 you see being described in the public record by the
4 actuaries as they try and assess the actuarial
5 drivers and then the business response.

6 Yes?

7 MR. BRANCO: Can you go back to
8 slide 40, or go ahead to Slide 40?

9 What I was really curious about,
10 when Dr. Hurlburt mentioned that he lived most of
11 his productive life on the left side of that
12 screen, as a lot of people in this room have, what
13 was the ah-hah moment that you took off of this
14 slide? Because there are so many elements here,
15 and I was hoping you'd get more specific on what
16 you saw as the revelation here as we move to the
17 right-hand side.

18 MR. FOSTER: I had about four
19 slides in the first draft, and I just said, "There's
20 just too much here for the amount of time I have."
21 So let me start with that caveat and then suggest
22 that when I take the historic slice and come back,
23 there is a lot of rich data here about a cost
24 containment story in hospitals, in pharmaceuticals,
25 cost-leveling stories, and I have a slide with about

1 six bullet points on it, drilling down into, "Hey,
2 there really is some interesting anecdotal
3 information about 'We were able to contain costs.'"

4 Partly the economy grew, and you
5 have sort of enrollment changes, but then there
6 were some additional factors on top of that. So
7 there is some rich information there I think that's
8 useful.

9 And then the other thing is when I
10 went through that, and then the thing that was
11 really striking was when I just plotted up the MESA
12 data and went, "Wow." You know, we can look at a
13 percentage growth rate in a chart, but when I plot
14 it, it just goes, "Okay. Now I see it, and now I
15 get a better feel for it." And so that's the other
16 sort of ah-hah moment, if you will, looking through
17 it.

18 And so that's the -- you know, you
19 want to really think, "Okay. Let's decompose
20 what's mostly driving this," and the answer is,
21 it's demographics. We're really sort of assuming a
22 rapid growth in the population, and they're going
23 to utilize those services that are available. And
24 it's the rapid growth in the population that
25 utilizes those services.

1 MR. BRANCO: My big issue is I
2 can't differentiate the colors.

3 MR. FOSTER: Ah-hah.

4 MR. BRANCO: That's why I was
5 asking about the ah-hah moment.

6 MR. FOSTER: These are in order.
7 The home and community based waiver, and this is
8 personal care, and there is inpatient hospital. So
9 you just go down the stack in order. And that's --
10 I'm sorry about that. So there is inpatient, and
11 there is physicians, outpatient hospital. And then
12 you get down into sort of the other stuff.

13 MR. BRANCO: Thank you.

14 MR. FOSTER: The two big ones are
15 the two at the top.

16 CHAIRMAN HURLBURT: My thinking
17 was, those two I had thought of as being in the,
18 quote, other third, roughly. And now that's -- and
19 as Mark showed in another slide, what you call
20 "health care" is open to definition. We tend to be
21 fairly broad in the United States in what we sweep
22 into health care. But this is clearly a part of it,
23 and it's clearly going to be eating everything
24 else's lunch. And about three-quarters of that is
25 paid by Medicaid. So it's a specific issue.

1 Emily?

2 MS. ENNIS: Yes. I wanted to
3 comment on the slide as well. So thank you, Pat.

4 The left side of the graph, as it
5 relates to home and community based waivers and
6 personal care, is a partial reflection of services
7 paid by Medicaid just beginning in those years. We
8 didn't have waivers prior to that time to pay. We
9 need to remember that the State of Alaska paid for
10 those services, and paid quite a bit. And we
11 refinanced dollars, as perhaps in that big bump up
12 there shows in the early part of the graph. That
13 reflects the refinancing from state to waiver
14 funding.

15 And the significant growth
16 definitely is attributable to not just services
17 being paid by Medicaid, but also growth in
18 population. But we do need to remember -- and I
19 wondered if you would comment on this -- is what
20 we've done in Alaska is, by providing those home
21 and community based services, we've reduced the
22 need for other services, more expensive services,
23 to be provided through those other categories.

24 The folks that are receiving those
25 services in those two rapidly increasing lines will

1 continue to need services. And if those home and
2 community based opportunities aren't there for
3 them, they are going to be contributing to
4 increased dollars in the other categories. So
5 they're not going to go away. It's the shifting
6 problem, once again.

7 But there are, you know, a number
8 of reasons; but I did want people to know that
9 those dollars were originally state dollars paying
10 for those services.

11 CHAIRMAN HURLBURT: Dave and then
12 Noah.

13 MR. MORGAN: I was going to make
14 basically the same point. You have four types of
15 waivers. Three of them, especially the one dealing
16 with older individuals, you basically do see -- you
17 did see a shift from residential and long term care,
18 or at least delaying it using the waiver program.

19 The fourth waiver, in my own mind,
20 you're just moving it from one column to another.
21 We always had to deal with that customer/patient,
22 whatever. So sometimes you got to go into the
23 weeds to break it down so you find the drivers.

24 Three of the four waivers, though,
25 in my mind, just in my experience, do reduce long

1 term and residential assisted living type
2 situations, which cost more than those waiver
3 programs.

4 The fourth type of waiver, I don't
5 know which modality actually is more cost
6 effective. My natural reaction is they are very
7 close, but I haven't really heard any problems or
8 complaints like you used to hear when they were
9 basically in facilities versus being treated the
10 way they are under waivers.

11 But, like I said, we're all
12 waiting for this. I think this is the gold that
13 will help us make some decisions and
14 recommendations. And I have to say it's great that
15 you're getting there.

16 CHAIRMAN HURLBURT: Noah?

17 DR. LAUFER: I'm sorry to be
18 abstract again, but I don't know -- you look at a
19 curve, a curve that has a continuously accelerating
20 slope. They don't continue to accelerate. They
21 collapse; right? It's a bubble. And this is true
22 whenever we see these things, so you can't project
23 and say, "By this year, it's going to be straight
24 up"; right?

25 So I know it sounds idealistic,

1 but when it crashes, if it all completely crashed
2 and there was no insurance or whatever, the real
3 fundamental question -- it's like a depression:
4 What do I really want? What am I really willing to
5 pay for at a minimal level? And that's -- I think
6 that's where we have to start. It's hard to -- you
7 know, we can't say what people will do in the
8 crisis; but a crisis is coming, and we could have
9 some idea of what really fundamentally matters.
10 You know, that's where I think the sense of urgency
11 comes from. Bubbles don't continually grow; right?

12 MR. FOSTER: If I was looking at
13 the data in 1980, I probably would have made the
14 same response that I'd make now, which is: I agree.
15 Bubbles don't continue to grow. But the bubble has
16 grown from 1980 to 2010 at roughly the same rate in
17 terms of the overall growth in health care spending,
18 and it seems to be growing more rapidly than income
19 growth. So --

20 DR. LAUFER: Bigger population.

21 MR. FOSTER: Right. And that may
22 very well be. So I just want to caution -- you
23 know, I'm sitting here at a particular point in
24 time, and the indications to me are it can't
25 continue to grow. But I also want to temper that

1 with the knowledge that if I would have been looking
2 at the same data in 1980, I would have made the same
3 conclusion, and I may have been wrong. And so
4 that's all.

5 CHAIRMAN HURLBURT: In a sense,
6 what you're describing as a post-collapse situation
7 is what Oregon tried to do in the '90s, and then CMS
8 told them they couldn't do it. They said, "Okay.
9 We do have a limited amount of resources." And
10 using evidence-based decision-making and other
11 factors, they tried to do that. So there has been
12 some attempts there.

13 Wes, did I -- did you have a
14 question, or was I misreading your body language?

15 REPRESENTATIVE KELLER: I asked --
16 I was just -- I think part of it was answered, but I
17 was trying to figure out what the projections -- how
18 they are affected by the presumptions related to
19 PPACA, you know, from the defining slide there.

20 MR. FOSTER: Yeah. And this was
21 the baseline projection without that in there.

22 REPRESENTATIVE KELLER: Without
23 PPACA?

24 MR. FOSTER: This is without. Yes.

25 REPRESENTATIVE KELLER: Okay.

1 Thanks. I missed the fine print.

2 MS. ERICKSON: But you do have
3 another slide that has it in, though, too; correct?
4 But not --

5 MR. FOSTER: Not in this slide
6 pack.

7 MS. ERICKSON: It's not in that
8 slide pack? Okay.

9 MR. FOSTER: That is correct. I
10 had to try and get it down to 40, because I knew
11 that would push the time limit.

12 CHAIRMAN HURLBURT: Yes, please.

13 REPRESENTATIVE KELLER: Again, this
14 is probably just another fine point, but on the
15 previous slide that you had up on the comparison of
16 the Medicaid costs, U.S. and Alaska, does that -- do
17 you have the data, and would it indicate anything to
18 us to show the comparisons per capita, as opposed to
19 the gross increase? Do you think the rate of
20 increase per capita has been the same as it had been
21 over the years?

22 MR. FOSTER: The short answer is I
23 do have the data, and rather than trying to do a
24 quick off-the-cuff summary characterization, I'd
25 prefer to get you a chart --

1 REPRESENTATIVE KELLER: Thank you.

2 MR. FOSTER: -- and a narrative to
3 go with it.

4 CHAIRMAN HURLBURT: To be true to
5 the meeting setting and the time, Linda and Val, do
6 you have questions?

7 MS. DAVIDSON: So my question
8 was -- really great data, great information.
9 Totally loved it. One question for Deb, I guess,
10 is: Are we going to get a copy of this PowerPoint
11 presentation?

12 MS. ERICKSON: Not this exact one.
13 So that's what we were mentioning earlier.

14 MS. DAVIDSON: Okay.

15 MS. ERICKSON: But the question for
16 Mark is: When will we get it?

17 MR. FOSTER: I think the short
18 answer is you won't get this one, in part because
19 I've got to go through and reconcile some data that
20 still doesn't match up. This is close.

21 MS. ERICKSON: Okay.

22 MR. FOSTER: But I don't want to
23 distribute it until I basically do some
24 reconciliation between Medicare, Medicaid, and
25 private so I can make sure all the pieces are adding

1 to the total, and doing that work. And then you'll
2 get something like this as a chart pack.

3 MS. ERICKSON: I think it would be
4 helpful, just to answer the question a little bit
5 more, too, to understand that our contract, the
6 commission's contract with ISER, under which Mark is
7 producing this work, ends the end of our state
8 fiscal year, the end of June. But actually the
9 timeline in the contract for production of the
10 deliverables is, I think, May. Does that sound
11 right?

12 MR. FOSTER: I think it is, yes.

13 MS. ERICKSON: Anyway, you're going
14 to get a chart pack eventually that might still be a
15 draft.

16 MS. DAVIDSON: So yes, but not now?
17 Okay. Got it.

18 MS. ERICKSON: That's it.

19 MS. DAVIDSON: So my real -- my
20 other question is -- because I was sort of trying to
21 figure out -- I mean, I'm not a data person. I'm
22 not a finance person. I'm a visual person, so I was
23 trying to keep track of slides, so it was a little
24 bit challenging for me. I understand why you have
25 to keep this close if it's not complete.

1 But I guess what lost me -- what I
2 got lost in in all these slides -- it was great
3 information, but I want to know: What's the moral
4 of the story? In the midst of all of this fabulous
5 data, what's the moral of the story, and what are
6 the three take-aways -- or five, if you need
7 five -- that this Health Commission should -- what
8 should we know, based upon these slides, that will
9 help to shape our work?

10 MR. FOSTER: I think Slide 45.
11 Just be mindful of cost control efforts in one area
12 frequently result in costs being shifted somewhere
13 else. So you really want to be careful that you
14 don't try a simple solution that may fix one
15 person's problem and creates two others for somebody
16 else.

17 Our ability to shift costs around
18 going forward looked to me and others to be much
19 more limited than it has been in the past. We've
20 been essentially wealthier on many different
21 levels, both in our household incomes and in the
22 federal support and all those sort of outlooks, and
23 we were able to shift costs around a little bit
24 easier; and now there is going to be more pressure.
25 So we want to be mindful of that overall pressure.

1 And then I think the other piece,
2 the third point is: We want to be mindful --
3 ultimately, all these pressures come down, and they
4 come to bear in a local community. And it's a
5 local referral region, and the individual providers
6 within that region that have to work together to
7 figure out: How do we most productively provide
8 care and still balance the local access and the
9 quality for our community?

10 So that's really where you want to
11 try and focus, and the sort of solution is: How
12 does that local community work and make progress,
13 whether that's Anchorage or Ketchikan, or Anchorage
14 and the Mat Valley?

15 And so when you draw your radar
16 rings out, you really get to appreciate that we're
17 all integrated frequently in our regions, not just
18 within a city. And so you want to be mindful of
19 that.

20 MS. DAVIDSON: So it's about
21 capacity?

22 MR. FOSTER: It's about capacity
23 and it's about working together to provide the
24 service, recognizing these pressures are coming to
25 bear. How do we do that? You know, and there are a

1 lot of acronyms out there, but I think ultimately
2 it's: How does the local community solve that
3 problem?

4 And then, finally, I think it's
5 the important overall driver, which is: We don't
6 have as many workers as other places to support our
7 young and older population, so we're going to put
8 pressure on our system because of just the basic
9 demographics. We're going to have to carry more
10 than other places. Even if we get more efficient,
11 we're just going to wind up carrying more. We're
12 going to have a horse race.

13 So I think those are the things
14 that I take away when I try and get back up and go:
15 What's really the key consideration as you think
16 about the problem and potential solutions? What do
17 you want to be mindful of as you work your way
18 through? That's the take-away.

19 MS. DAVIDSON: Thank you.

20 CHAIRMAN HURLBURT: Thank you.

21 Linda?

22 MS. HALL: I don't know that I have
23 any actual questions, and I think Val hit on where I
24 go when I look at this kind of data. And it is
25 great data, but it's still data. And we have to

1 decide what we do with it.

2 Probably my repeated statements in
3 this group have dealt with costs of health care. I
4 see that, and I talk about it, and I approve health
5 insurance rates based on that. And it's
6 interesting to me to see if that slide with all the
7 colors that I can't figure out exactly -- I can see
8 the order. But where you see components, you see
9 utilization, you see age-related issues. But I
10 think I'm still concerned that, as a commission, we
11 deal with -- and I would guess I say the third
12 bullet point there: How can we find ways to
13 deliver services differently, deliver services more
14 efficiently?

15 I like the balloon analogy,
16 because I don't think we can put pressure on one
17 place without it exploding someplace else. We have
18 a huge amount of cost shifting, and that doesn't
19 really solve anything. It just shifts who pays.

20 But we still want local access and
21 quality, and I'd not ever thought before of the
22 impact of increasing incomes on what people want,
23 the services we want. I think it, at some point,
24 becomes a value judgment; and I don't know that
25 anybody in this group wants to start making those

1 judgments.

2 But at some point, we have to
3 decide: How much care can we afford as a group
4 unless we can find ways to make it more efficient?
5 How much of our gross national product? How much
6 of our state product can we afford to put into
7 health care?

8 I'm rambling now, but those are
9 thoughts that I had as I watched this. And I'm
10 still back to cost. And you've shown us cost and
11 cost drivers, and we need to then take that and
12 translate it into recommendations.

13 CHAIRMAN HURLBURT: Thank you. Any
14 last questions? We probably should move on.

15 Mark, thank you very much. We
16 recognize this is a work in progress, and we
17 appreciate your continuing to pursue it. We will
18 very much look forward to getting the next product
19 when it's available, recognizing that that will
20 still not be the end, that there will be more work
21 to do on that. Thank you very much.

22 The next about half-hour, I guess,
23 or just a little bit more, we want to talk about
24 some definitional kinds of things, and I think Deb
25 is going to lead us in that. And then we'll plan

1 to break by 11:45 for lunch. And as Deb said,
2 there will be time for all who would like to join
3 the short walk from the Capitol Building down to
4 Marine Park related to the efforts related to
5 domestic violence and sexual abuse in our state.
6

7 GROUP DISCUSSION

8 COMMISSION DEFINITIONS FOR HEALTH, HEALTH CARE,
9 HEALTH CARE CONTINUUM, HEALTH CARE SYSTEM
10

11 MS. ERICKSON: So behind tab 3 in
12 your notebooks is the definitions PowerPoint. And I
13 had also included in that section of your notebook,
14 if you had a chance to look at it before the
15 meeting, a copy again of Appendix A from the
16 commission's 2009 report, which was a report
17 describing how health care in Alaska is delivered
18 and financed.

19 And I mentioned in the e-mail, I
20 think, when I distributed that or in your homework
21 page that I included that just as a reminder -- and
22 it's 40 or 50 pages long -- and suggested that I
23 understand that that was too long of a definition,
24 and we wanted some one- or two-sentence definitions
25 for some of these major terms.

1 But I think in that first year we
2 were focused very broadly on the full system and
3 trying to make sure that we were describing the
4 full system, all the aspects of the services that
5 we were considering as we were moving forward with
6 planning to plan for the health care system.

7 But I thought it might be helpful
8 for you to just have that resource at your
9 fingertips as we talked about this and as we moved
10 towards trying to come up with some specific one-
11 or two-sentence definitions.

12 And these were the terms that I
13 was remembering you all had asked that we develop
14 specific definitions for for our operating
15 purposes: health, health care, health care system,
16 and health care continuum. So I hope I got that
17 list right. If there is anything else you feel we
18 need to add to the list, we can do that.

19 So any questions or comments,
20 before we start talking, about how we might want to
21 define "health"?

22 As we're talking about health --
23 actually, I didn't bring it with me to the table.
24 I probably should go get it. But I did throw in at
25 the last minute in your packet -- so it's not on

1 this slide -- it's a definition of the "health
2 promotion" that I just came across in the American
3 Journal of Health Promotion. And embedded in it,
4 further down, is their definition of "health."

5 What caught my eye when I saw that
6 is the circle diagram and the picture of how that
7 particular journal defines health. But I was taken
8 by that graphic. And so I'm sorry I don't have it
9 on the slide, but you have it in your notebooks.
10 I'm going to actually grab it, and I'll give you a
11 minute to look at it.

12 And what I did was I just pulled
13 up -- these were the three most common definitions
14 that I came across in researching how different
15 groups define "health," starting with the World
16 Health Organization. The graphic is behind the
17 slides. It's right before the purple divider page
18 in front of Appendix A.

19 MS. DAVIDSON: Behind tab 3?

20 MS. ERICKSON: Yes, it's behind
21 tab 3.

22 So starting with the definition
23 that I'm most familiar with from 25 years working
24 in public health and one we typically use in
25 various projects is the World Health Organization's

1 definition. I noted that this definition hasn't
2 been amended by the World Health Organization since
3 1948. "Health is a state of complete physical,
4 mental, and social well-being and not merely the
5 absence of disease or infirmity."

6 The second example definition from
7 Merriam-Webster's medical dictionary: "The
8 condition of being sound in body, mind, or spirit;
9 especially freedom from physical disease or pain."

10 And then I came across this one
11 numerous times and couldn't find an actual
12 dictionary that noted it as a definition; but in
13 numerous reports and websites, this definition was
14 described as the medical field's definition of
15 health: "an organism's ability to efficiently
16 respond to challenges (stressors) and effectively
17 restore and sustain a 'state of balance' known as
18 homeostasis."

19 And I took time to read through
20 those, because they are short, mostly for the folks
21 who are listening online. This PowerPoint is on
22 our meeting website for folks who are really
23 following closely over the web, listening to the
24 audio.

25 I'll give you all a chance to

1 review those again, too, and then maybe I'll just
2 note for folks who don't have it in front of them
3 the circle and the Journal of Health Promotion's
4 definition. They note that "Optimal health is a
5 dynamic balance of physical, emotional, social,
6 spiritual, and intellectual health."

7 And so they have a circle that
8 shows physical in a center circle with rays going
9 out and circle divided, then, into the four other
10 sectors of social, intellectual, emotional, and
11 spiritual. And it even has a little note about
12 what each of those five areas represents. For
13 "Physical" it's "Fitness, nutrition, medical
14 self-care, control of substance abuse."

15 "Emotional: Care for emotional
16 crises and stress management."

17 "Social: Communities, families,
18 and friends."

19 "Intellectual: Educational
20 achievement and career development."

21 And "Spiritual: Love, hope, and
22 charity."

23 So I will just open it up for
24 conversation and questions, your thoughts about
25 these various definitions and your suggestions for

1 what the commission might do. We'll start with Pat
2 and then Noah and then David, if he had his hand
3 up.

4 MR. MORGAN: No.

5 MS. ERICKSON: Okay. And then
6 Linda. Pat, Noah, and Linda.

7 MR. BRANCO: I might actually jump
8 ahead of Noah. From what we've heard a few times
9 this morning, the new definitions that are coming
10 out into a person's well-being and their holistic
11 view of themselves -- these tend to be a more
12 technical representation of what we view everyone
13 else's health in. And I don't see, other than the
14 spiritual element on the circle diagram, where it's
15 the individual's assessment of their own well-being
16 or their own centeredness.

17 DR. LAUFER: I think that's exactly
18 right, and that actually is the crux of this. These
19 are outdated. Like the World Health Organization:
20 "The absence of diseases or infirmity," that isn't
21 life. We live now with disease and infirmity, and a
22 lot of people live at least half of their life with
23 significant disease and infirmity and pain. And the
24 question is: How do you help them to do that in the
25 context of the narrative of their life in a positive

1 way for a reasonable cost?

2 It's very expensive to live after
3 your bone marrow transplant, your coronary artery
4 bypass and, you know, with chronic disease and pain
5 and artificial disks. Human life includes disease
6 and infirmity, and those people can still be
7 healthy, in my mind, and that they're capable of
8 coping with it. Does that make sense? Those are
9 the guys that cost you a lot of money; right? All
10 of us.

11 MS. ERICKSON: So I just want to
12 make sure I understand. Would we want to --

13 DR. LAUFER: This fits in with that
14 fallacy of, you know, mortality rates. The
15 mortality rate is 100 percent, and it's more a
16 question of: Between birth and mortality, how is it
17 going? Again, as I said: How you are doing with
18 your chronic pain? How you are dealing with your
19 chronic medical issues that hurt you and impact your
20 life? And that's a very different question from
21 what intervention can we do.

22 MS. ERICKSON: I want to make sure
23 that I understand what you're suggesting, and then
24 Linda was next, and then Colonel Friedrichs and then
25 Val. So --

1 MS. DAVIDSON: This whole side.

2 MS. ERICKSON: Am I just looking at
3 this side? Do you guys have your hands up too?

4 Let me -- I want to make sure I
5 understand. Are you suggesting that somebody who
6 is not physically healthy, that we would have a
7 definition that would actually consider them as
8 being in a state of health? And let me -- hold on
9 to that question, because I don't know if this will
10 help or not. I brought with me a definition of
11 healing. It's different from health. And when I
12 read this, I actually thought of you and some
13 similar comments that you've made in earlier
14 meetings, Noah.

15 "Healing is a restoration of
16 wholeness and unity of body, mind, and spirit. It
17 involves cure when possible but embraces more than
18 cure. When we limit illness to disease and health
19 care to cure, we miss the deeper dimensions of
20 healing."

21 DR. LAUFER: I like that. Yeah.

22 MS. ERICKSON: I see heads nodding.

23 DR. LAUFER: Yeah.

24 MS. ERICKSON: So we could augment
25 a definition of health, whatever we end up coming up

1 with, with a definition -- our definition of
2 "healing." That's a suggestion. We don't have to
3 decide that this second. And if you want me to type
4 that up, I can do that. But that -- does that give
5 you some more --

6 DR. LAUFER: Yeah. It sounds like
7 an abstraction, and the silly thing is, it really
8 isn't. The high utilizers are not -- they're not
9 healthy by that standard, but they are not dead.
10 They are living with expensive, terrible, difficult
11 things. And the way that the system is set up now,
12 everybody wants to get their hands off of them,
13 because they are difficult and painful to deal with.
14 It's not as rewarding, and you're not reimbursed for
15 it. And they are a high risk for everybody, you
16 know. But they are alive, and those are the people
17 we have to care for, and that's the state we want to
18 prevent.

19 MS. ERICKSON: And the related
20 comments that you've made in past meetings are that,
21 for some people, they will never be brought to a
22 complete state of health, but that doesn't mean
23 there isn't a healing relationship involved in the
24 provision of their care.

25 DR. LAUFER: They can still be the

1 hero of the story of their life.

2 MR. CAMPBELL: Can you read that
3 one more time?

4 MS. ERICKSON: I will read it. I
5 was just asked to read it one more time, and then
6 we'll go to Linda and then Paul and then Val.

7 "Healing is restoration of
8 wholeness and unity of body, mind, and spirit. It
9 involves curing when possible but embraces more
10 than cure. When we limit illness to disease and
11 health care to cure, we miss the deeper dimensions
12 of healing."

13 Linda?

14 MS. HALL: I think my comments were
15 going to be along the nature of the ones that have
16 been made, that we see people daily who -- and I
17 actually had a discussion with a couple of people in
18 my office about this, because I think what I'm going
19 to say is probably more an Eastern philosophy than
20 what I read in some of those definitions.

21 We see people with chronic
22 disease. We see people in pain. They still lead
23 full, happy lives. I don't think the absence of
24 disease or infirmity is -- I think you're still
25 healthy. I mean, as we -- as I age, I have an

1 issue with me knee. I'm still very -- I think I'm
2 still very healthy.

3 So I'm not sure how we separate
4 that from health. And certainly we need to treat
5 people, but I think we need to consider the whole
6 being also. There is a -- I guess I said this is
7 going to sound like an Eastern philosophy, but
8 there is a spiritual side. There is a mind and
9 body and spirit. I kind of like that part. But
10 most of these I think -- and I just agree -- are
11 outdated, and I do like the concepts in the healing
12 definition.

13 MS. ERICKSON: Paul?

14 COL. FRIEDRICHS: Two points
15 related to that. The first is: Absolutely health
16 should be defined by the individual, rather than us
17 saying that they are healthy or unhealthy, and,
18 therefore they're entitled to X, Y, and Z. That's a
19 personal determination of one's health status.

20 I think what you read about health
21 care is very useful. Where this becomes
22 particularly important -- and this gets back to the
23 last presentation on where we're going in the
24 future -- we're already beginning to collect
25 genetic data on people. We know, as it turns out,

1 as Noah correctly said, everybody dies. It turns
2 out everybody has bad genes of one sort or another.
3 If we define health as the absence of bad genes,
4 ain't nobody healthy in the United States.

5 And that is the bow wave that is
6 about to hit in medicine as a whole, that within
7 the next five years, the whole practice of health
8 care will be redefined from "We're just talking
9 about your immediate, acute problem, whatever it is
10 that you've identified," to "15 years from now,
11 based on our genetic analysis, you are at a
12 significant risk for developing X,Y, and Z, and
13 here are our recommendations to mitigate that
14 risk."

15 That's the reality of where health
16 care is going, so I would encourage the commission,
17 as we consider this, to adopt a holistic viewpoint
18 from the individual's perspective, but also
19 recognizing that health care, as most of us learned
20 growing up -- which was pick up the phone and wait
21 for Marcus Welby, M.D., to say you can go to school
22 or not -- I mean, that is so far in the past it
23 certainly will not shape the future of health care
24 delivery.

25 MS. ERICKSON: Val?

1 MS. DAVIDSON: I guess -- and I
2 apologize. I missed the last meeting. But I'm
3 looking at our charge, our statutory charge of what
4 we're supposed to do, and I'm confused about why
5 we're taking, you know, 30 minutes or longer, given
6 our huge agenda of all of these things we have to
7 do. And one of the things that's not in our charge,
8 statutory charge, is to define "health," "health
9 care," "health care system," or whatever we're
10 trying to define. I think we could probably be here
11 for days on just these definitions, and I don't know
12 that we're necessarily going to get there.

13 And so I apologize if it was -- if
14 we decided at the last meeting that this was
15 absolutely critical to moving forward, but I'm just
16 sort of wondering if we have a limited amount of
17 time to be able to accomplish all of these things
18 on the agenda and we haven't even accomplished one
19 of them yet, do we really want to spend our limited
20 time between now and when our January report is due
21 defining terms, these terms?

22 MS. ERICKSON: One, I am just
23 following orders, so if you all want to take this
24 off the agenda for today, that's okay with me.

25 Two, I was hoping that we could

1 get to decisions in the next 15 minutes on each of
2 these and move forward after some conversation and
3 be done with it. So --

4 MS. DAVIDSON: So, I guess, what
5 are these terms going to be used for?

6 MS. ERICKSON: They are going to be
7 used to frame our conversations in the future, is
8 what I remember the conversation at the last meeting
9 being about. Were we using -- when we mentioned
10 "health" and "healing," were we talking about the
11 same -- were each of us thinking about the same
12 thing in the course of our conversation, or are we
13 thinking about different things when we talked about
14 "health care" and "health care system"?

15 The conversation came out of the
16 request that we look at long term care. And the
17 question about the -- the question was: Are we
18 considering -- we, the commission -- is long term
19 care inside, or outside, the circle of health care
20 when we say we're planning for health care?

21 And that's why, again, I included
22 the Appendix A, because, well, yeah, but we hadn't
23 got down to the level of looking at specific
24 services yet. So that's where the -- that's what
25 started that conversation.

1 MS. DAVIDSON: Thanks.

2 MS. ERICKSON: And I did offer and
3 asked if this would be helpful. So --

4 MS. DAVIDSON: Thanks. I wasn't at
5 the last meeting, so I apologize. I sort of -- was
6 sort of stepped into the middle without the context
7 of what the purpose was. Thanks.

8 MS. ERICKSON: Paul, and then I
9 need to make sure -- see if there is anybody on this
10 side.

11 COL. FRIEDRICHS: I think, Val,
12 part of what I remember from the last meeting and
13 discussion was we will never solve everybody's
14 desire for everything. And that was part of what we
15 spent a lot of time talking about is: What are the
16 constraints within what we can recommend here? You
17 know, where are we going to be able to say "This is
18 within our purview" and "This is not"?

19 Health is a person's -- an
20 individual's assessment: "I am healthy," or "I am
21 not." And certainly -- I was talking to someone
22 last week who spent several years in a
23 concentration camp; who is elderly; who is, by my
24 estimation as a physician, troubled with many
25 medical conditions. She considers herself

1 profoundly healthy. She considers herself to have
2 been, you know, the recipient of a miracle to have
3 survived what she went through and to be alive and
4 still enjoying her family. And she views herself
5 as healthy.

6 If we try and build a health care
7 system in which the goal is to address every
8 medical problem, we'll spend an infinite amount of
9 money, because there is an infinite number of
10 medical problems out there. If, instead, we take a
11 more holistic approach, as our colleagues at
12 Southcentral have urged when we've met them -- for
13 example, talking about pain management -- to look
14 at the whole person and what the whole person needs
15 from the community, from themselves, from health
16 care providers, from non-health-care providers,
17 that may help us to scope, to some extent, what
18 this commission recommends along the way.

19 This commission can't take on the
20 spiritual dimension of personal health, and I think
21 we ought to acknowledge that up front. There are
22 individual aspects to the definition of "health,"
23 and none of our bills that -- recommendations that
24 we'll bring forward to the Legislature can presume
25 to solve health care problems; but we have to agree

1 on what those are.

2 MS. ERICKSON: Yes, Emily.

3 MS. ENNIS: I appreciate the
4 opportunity to expand my own thinking and concepts
5 of what health care is all about. And I do
6 appreciate the opportunity to begin helping others
7 understand why we need to consider that long term
8 care is a part of health care planning, particularly
9 because the individuals that are using our long term
10 services, long term care services, certainly, in
11 many respects, see themselves as people who are
12 enjoying life still and want to.

13 But then, furthermore, I think
14 this discussion really reinforces the excitement I
15 felt when I read the article by the futurist. That
16 caused me to think so differently about our health
17 care services and what we can do to change the
18 future of costs and how they are applied.

19 And part of that is looking at the
20 whole person, encouraging employees to look at
21 themselves as whole people and what their impact
22 can be on the cost of health care and how health
23 care is provided.

24 So I think this is all part of
25 expanding our consciousness somewhat, and I do feel

1 that it's helping lay the framework for my
2 thinking. So thank you.

3 MS. ERICKSON: Okay. So what if
4 I -- do you like the definition that the health
5 promotion experts have provided, coupled with the
6 definition of healing? I'm seeing heads nod. In
7 the interest of trying to move things along quickly,
8 what I would like to do is redraft this definition
9 of health and maybe just share it over e-mail and
10 see if you have any other tweaks you want to make to
11 it.

12 And moving on to "health care"
13 quickly, the Wikipedia definition: "Health care is
14 the diagnosis, treatment, and prevention of
15 disease, illness, injury, and other physical and
16 mental impairments in humans."

17 I'm not going to read all of
18 these, but just out of curiosity, Linda had
19 mentioned to me, "Well, I have 'health care'
20 defined in my state law." And I found three
21 different places -- actually, there were several
22 places, but I pulled out three examples where
23 "health care" is defined in state law related to
24 specific issues.

25 One pertains specifically to

1 advanced health care directives; Linda's, of
2 course; and another, older definition pertaining to
3 patient access to records, where 'health care' is
4 specifically defined in the definition section of
5 an area of state law.

6 Do you still want to define
7 "health care," and do one of these jump out at you?
8 The first and the third there, the one that I just
9 read, aligns pretty closely with advanced health
10 care directives.

11 MR. BRANCO: And none are
12 contradictory?

13 MS. ERICKSON: None are
14 contradictory. Do those work for you? Or would you
15 rather not have a definition of "health care" at
16 this point?

17 Jeff?

18 MR. DAVIS: Thank you, Deb. I like
19 the third one there, the one pertaining to advanced
20 directives, because it's broader and I'm just
21 thinking about my own personal experience. I've had
22 some experience over the last four or five months
23 that has caused me to actually focus on diet and
24 exercise and, as a result of that radical thinking,
25 I've lost 36 pounds and don't have high blood

1 pressure and don't have messed-up cholesterol
2 anymore.

3 DR. LAUFER: You look good.

4 MR. DAVIS: Thank you.

5 And that was not because of an
6 intervention by a licensed health care
7 professional; it was an intervention by someone who
8 assessed my resting metabolic rate.

9 So that would fit into this third
10 one; and probably, as my fourth-year-medical-
11 student son said, has, you know, a more profound
12 effect on my health than anything that medicine
13 could give me.

14 DR. LAUFER: And on the cost of
15 your health care.

16 MR. DAVIS: Oh, absolutely. It's
17 dropped by \$500 a month.

18 MS. ERICKSON: So I'm hearing a
19 vote for the third definition.

20 Val?

21 MS. DAVIDSON: The only thing
22 that's missing in this piece is the prevention
23 piece.

24 MS. ERICKSON: "Procedure to
25 maintain" -- so what if I take a stab at redrafting

1 that third bullet just to make sure that prevention
2 is more clear?

3 MR. DAVIS: I was seeing that as
4 under "otherwise affect an individual's physical or
5 mental condition." That's how I would see it.

6 MS. ERICKSON: Do you want to be
7 more -- Val, do you want to be more explicit about
8 prevention? I won't wordsmith it right now, but
9 I'll do the same thing and take a stab at that.

10 Any other comments, thoughts,
11 questions, suggestions? Are you all comfortable
12 with me playing with the third suggested definition
13 there and adding "prevention"? I'm getting thumbs
14 up.

15 Paul?

16 COL. FRIEDRICHS: I'm very
17 comfortable with you wordsmithing it, and I'll ask
18 our legislative colleagues here to advise us. You
19 know, on the federal side, this is one of the
20 crazy-makers, when you have multiple definitions for
21 the same thing in different parts of the federal
22 code. And so we always try and bring that forward
23 as a suggestion to our federal legal colleagues or
24 legislative colleagues, that this would be helpful
25 if there were one definition for this so that we all

1 understand what it is that we're talking about.

2 I don't know if that's something
3 that would be helpful in this case for the state to
4 have one definition rather than three somewhat
5 disparate definitions along the way. I would
6 welcome feedback on whether that's something that
7 the commission should address.

8 REPRESENTATIVE KELLER: It might be
9 more helpful, but I think it would be a futile
10 exercise to try to, you know, make them all the
11 same. And the next person that would write a bill
12 would come up with another one.

13 It's interesting -- that third one
14 I helped write.

15 MS. ERICKSON: Good job.

16 Any other final questions or
17 comments on health care?

18 "Health care system" -- this is
19 actually awkward. I had a difficult time finding a
20 definition of "health care system." Anything I
21 found, for the most part, was actually a
22 description, more of a description of what health
23 care systems are, and that's why I just threw in a
24 sentence from our Appendix A, that "People in
25 Alaska obtain health care through three different

1 systems: the private sector, the military and
2 Veterans' Administration, and the Alaska Tribal
3 Health System." That's how we tend to look at our
4 systems in Alaska and how we've described them in
5 our 2009 report.

6 But that first bullet, "A health
7 care system is a collection of organizations,
8 practitioners, and supporting workforce; facilities
9 and technologies; financing mechanisms; policies;
10 and information that provide and support the
11 provision of health care for a population."

12 DR. LAUFER: It's not a system.

13 MS. ERICKSON: Well, we could
14 probably spend the rest of the day talking about how
15 we define "system."

16 DR. LAUFER: Like a food delivery
17 system?

18 MS. ERICKSON: It's --

19 DR. LAUFER: Throw some regulation
20 in. People get it elsewhere. Subsidize it. That
21 would be a mess. It's not a system; it's an
22 ecosystem. I mean -- I'm sorry. I'll be quiet.

23 MS. ERICKSON: Do you want a
24 definition of the "health care system," and does
25 this work for you? Do you want to spend more time

1 at the next meeting talking about what a "system"
2 means to you?

3 DR. LAUFER: No.

4 MS. ERICKSON: Okay. Is it helpful
5 to have this?

6 REPRESENTATIVE KELLER: Diagrams.

7 DR. LAUFER: Yeah. Diagrams.

8 MS. ERICKSON: I'm not seeing heads
9 nodding or shaking one way or the other.

10 DR. LAUFER: Do we have to define
11 it?

12 MS. ERICKSON: What's that?

13 DR. LAUFER: Do we have to define
14 it? Is it --

15 MS. ERICKSON: Well, that was one
16 of my questions. Do you want to define "health care
17 system," and if so -- yes, David.

18 MR. MORGAN: This is probably
19 totally inappropriate, but I'm going to say it.
20 Maybe we should, on some of this, just accept the
21 fact that you have many different people here from
22 many different backgrounds and industries and
23 educational background. I'm going to kind of hold
24 with the Supreme Court on their decision on
25 pornography. They can't define it, but they know it

1 when they see it.

2 Why don't we accept some general
3 definitions and move on? Because we could spend a
4 week on this if we wanted to, and we've got a whole
5 big bunch of stuff to do.

6 MS. ERICKSON: Yes, Val?

7 MS. DAVIDSON: So are we
8 deciding -- so we're going to with the "health care
9 system" definition? Because I think the "health
10 care system" definition is more important than the
11 other two, because it's what we have.

12 DR. LAUFER: Some people have a
13 system; that's true. And for a lot of people, it's
14 catch as catch can.

15 MS. ERICKSON: That's getting into
16 a discussion of how you define "system," I'm afraid.
17 And I think people are defining "system"
18 differently, and that's why -- here around the table
19 right now. So I'm hearing -- I heard David suggest
20 that we don't need a definition of "health care
21 system" at this point and Val suggesting that that's
22 the most important one.

23 If we were to have a definition,
24 does this first bullet, perhaps followed with the
25 second one, work for all of you? Or is it close

1 enough that if I distribute it as a draft for
2 follow-up over e-mail, you would be happy making
3 suggestions or tweaks to? Is there anything
4 fundamentally wrong with that that you want me to
5 work on?

6 MS. DAVIDSON: Not the first one.
7 But the second one, after "private sector," the
8 last -- the military, VA, and the Alaska Tribal
9 Health System are really federally funded health
10 systems, but the one that's missing is 330 clinics.

11 MS. ERICKSON: So you consider 330
12 clinics as separate? Because right now, they're
13 not -- for all intents and purposes, they'd be a
14 federally funded part of the private sector, I
15 guess, is the way we would include them. We don't
16 define them; we describe them. We don't define them
17 as a separate system. And I think in the past, when
18 we've identified these three majors systems, looking
19 more broadly -- more from a beneficiary's
20 standpoint, but very broadly -- in trying to capture
21 all of the different levels and types of services,
22 and 330 clinics are a specific -- I mean, it's just
23 primary care, for the most part, including
24 behavioral health, ideally, and dental services, and
25 doesn't include hospitals and other levels of care.

1 So that's why it's not broken out as a separate
2 system.

3 MS. DAVIDSON: Okay. It just
4 looked like it was missing.

5 MS. ERICKSON: Yes, Larry?

6 DR. STINSON: I'm fine with either
7 of the definitions, or the distribution for further
8 clarification of the distribution through e-mail.

9 MS. ERICKSON: Let's go with that,
10 in the interest of time.

11 And, finally, "health care
12 continuum" I actually just pulled right out of our
13 2009 report. The diagram that we'd included of the
14 continuum of care moving from least intensive, home
15 and community based services, and encompassing
16 prevention, early intervention, case management;
17 and, in the area of long term care, home-based
18 management/maintenance, up through community and
19 regional services and facilities, including
20 outpatient, day treatment, intensive outpatient,
21 with some examples listed.

22 And on the long term care
23 continuum specifically, home health skilled care
24 and assisted living, and then moving up to the most
25 intensive services being facility-based high-tech

1 inpatient medical treatment, residential services,
2 and nursing home services.

3 Does this work for you, with the
4 definition being "The health care continuum is the
5 full array of services, from prevention to
6 treatment to rehabilitation and maintenance,
7 required to support optimum health of a
8 population"?

9 I'm seeing heads not, thumbs up,
10 more thumbs up, more nodding heads. So I will
11 distribute this in the next draft for further
12 tweaking and finalization over e-mail.

13 Thank you all very much. And to
14 note that Senator Olson joined us at the beginning
15 of this conversation. And we have a couple minutes
16 before we're scheduled to adjourn at 11:45 for
17 lunch.

18 So, Dr. Hurlburt, I'm going to
19 turn things over to you.

20 CHAIRMAN HURLBURT: You just said
21 it. We started out with what are the expectations
22 of the Governor's office and the Legislature; and
23 your colleague, Representative Keller, did an
24 excellent job trying to speak for his 59 colleagues
25 there. And Deb and I filled in a little bit, based

1 on a conversation we'd had with Representative
2 Hawker and Senator Davis. But we really would
3 appreciate it if you could just share what some of
4 your vision and expectations were.

5 And this related to the last
6 meeting, also, with our newly reconstituted and
7 enlarged group, that that area seemed to be
8 important to address again.

9 SENATOR OLSON: Okay. Well, I hope
10 I'm not going to contradict anything that you said.

11 REPRESENTATIVE KELLER: Oh, I told
12 them that a lot of it -- that, you know, it was from
13 you.

14 (Laughter.)

15 SENATOR OLSON: As I look at it,
16 obviously a fair amount of money is being spent
17 here. And as we shape public policy, we want to
18 make sure that what we're doing is we're not
19 spinning our wheels. There have been commissions
20 before; there will be commissions in the future.
21 Hopefully, this will be the landmark commission
22 that's there in some of the decisions that are made
23 here.

24 I come from the perspective of if
25 you're going to go ahead and -- well, if you're

1 going to look to us for money, then we need
2 something that's fairly specific and something that
3 can be measured. So as we go out thinking about
4 building clinics or trying to have an effect on
5 diabetes or obesity or cancer and those kinds of
6 things, if you have specific ideas on where we can
7 go, what we're going to be spending the money on --
8 because right now, the flavor -- I just came out of
9 Senate Finance, and they're pretty -- the people
10 are coming out of there fairly wrung out, that are
11 presenting to us.

12 And so, because of that, I want to
13 make sure that if we have to go back up there and
14 start to sell a program, that we have some
15 definitive type issues and a plan of implementing
16 them. And I think we have a good chance of getting
17 them funded, partly because, as I look at the
18 surpluses coming in this year, there is going to be
19 a surplus again; and with the amount of money
20 that's put into savings, I think they are open to
21 health care.

22 And with Dr. Hurlburt's wise
23 leading that says, you know, if we don't do
24 something, this next generation of people that are
25 coming are not going to live as long as their

1 parents; and you people that are serving here in
2 the Legislature now, you're going to need health
3 care here in the very near future, and some pretty
4 intensive health care. And so I think they're open
5 to those kind of suggestions.

6 And with that, unless there are
7 further questions, those are my comments,
8 Dr. Hurlburt.

9 CHAIRMAN HURLBURT: Thank you. Any
10 questions for Senator Olson?

11 REPRESENTATIVE KELLER: I just
12 wanted to comment that that complements what I said
13 very well.

14 SENATOR OLSON: Thank you. Good.

15 REPRESENTATIVE KELLER: And that
16 was actually an advantage that we came in here
17 separate, because I think the commission saw two
18 perspectives, and that's good. It's perfect.

19 SENATOR OLSON: I tried to call him
20 to see where he was at this mining. "Oh, he's
21 already here? Okay. I'm on my way down."

22 So, okay. Thank you.

23 CHAIRMAN HURLBURT: Deb?

24 MS. ERICKSON: If you're ready to
25 be done, I should just say a couple of things before

1 we wrap up. Are we ready to wrap up for lunch?

2 CHAIRMAN HURLBURT: Yes.

3 MS. ERICKSON: Okay. I just wanted
4 to note, and I should have mentioned earlier, that
5 we do have lunch. We had things for breakfast
6 earlier today. They are across the hall. Everybody
7 who is here in the room with us, observing the
8 proceedings, are welcome to join us for lunch.
9 Those of you who are interested in going to the
10 capitol for the Choose Respect rally and march, that
11 starts in 15 minutes, and you have a map in your
12 notebook. It's just two or three blocks away. And
13 I think that's about it.

14 But if you all -- if the
15 commission members could try to be back in their
16 seats by about five minutes till 1:00 at the
17 latest, because we'd like to start the public
18 hearing right at 1:00. Sound good? Any questions
19 before we break for lunch? Thank you.

20 11:49 AM

21 (Off record.)

22 1:02 PM

PUBLIC COMMENT PERIOD

1
2
3 CHAIRMAN HURLBURT: If we can come
4 back to order now. We have a few folks on line. We
5 have one person here signed up to talk. Do we have
6 any folks on line specifically, do we know, that
7 have signed up that want to comment?

8 MS. ERICKSON: They didn't have to
9 sign up, so let them know that anybody who's on can
10 comment.

11 CHAIRMAN HURLBURT: Okay. We'll
12 keep it open. We won't necessarily go all the way
13 until 2:00. We'll probably want to end a little bit
14 before then, at the least, to move on with our
15 agenda.

16 But I'll ask now, is there anybody
17 on line that would like to have some public
18 testimony? Are they all un-muted? Do we know?

19 MS. SIMS: They should be. On my
20 end, they are.

21 CHAIRMAN HURLBURT: Okay. So
22 nobody right now on line.

23 We have one person here, I
24 believe, in the group, Lyn. Why don't you go ahead
25 with what you have. And I think normally we have

1 more folks and we need to make it shorter, but I
2 think probably as long as five minutes, if you want
3 to.

4 If you could introduce yourself
5 and say who you are representing when you start,
6 please, Lyn.

7 DR. FREEMAN: Good afternoon. My
8 name is Lyn Freeman. My specialty is behavioral
9 medicine for the treatment of chronic disease, and I
10 came today to share some information with you that
11 you perhaps may not be aware of. Also, to make some
12 suggestions of things that I think would be helpful
13 that could both improve quality of life and also
14 help reduce health care dollars. And I'll mention
15 that this information comes from clinical research
16 that has been produced in your state specifically
17 for an Alaskan population, and you may not be aware
18 of this.

19 Because I have to cover what is
20 typically a two-hour lecture in five minutes, I
21 guess, I put together a mind map for you so that
22 you'll be able to see and follow along as quickly
23 as I can with giving you the big picture as best I
24 can do here.

25 Essentially the little figure at

1 the top that shows all of the brains being juggled
2 is acknowledging that no one solution is going to
3 make a big enough difference to keep us from going
4 off of that cliff I've been hearing about all day.
5 It's going to take many minds approaching this from
6 many different ways.

7 However, there is one particular
8 area that has not been really looked at and
9 explored the way it should be that can make a
10 significant enough difference to help keep us from
11 being pushed off that cliff.

12 And if you look there, you'll see
13 that, first, we're talking about the problem; and
14 you've been talking about that all day, which is
15 simply that health care costs are unsustainable.
16 We know, if you look at the research, and depending
17 on the condition you're speaking about, that from
18 two-thirds to three-fourths of health care costs
19 could be prevented if there was adequate behavioral
20 change in relationship to chronic disease in the
21 population.

22 And the other thing that is
23 interesting is, when you drill down and say, "What
24 does this have to do with the State of Alaska?" on
25 top is the Department of Administration to look,

1 for example, at the costs for employees and
2 retirees. That's a good model. It's almost
3 identical to what you see at the national average.

4 You have four diseases that pretty
5 much eat your lunch, and what those are are
6 cardiovascular disease, diabetes, obesity, and
7 cancer. As of this year, cancer has taken over as
8 the number-one killer in our nation. It's left
9 cardiovascular disease as No. 2. I don't know how
10 many of you were aware of that. And I've heard
11 Dr. Hurlburt talk today about the cost of the drugs
12 for cancer treatment, so this is significant.

13 So these three diseases are what
14 we refer to in research to as "entangled." If you
15 are obese, you are more likely to have
16 cardiovascular disease and diabetes. If you have
17 diabetes, you're more likely to be obese and have
18 these other conditions. So they actually make a
19 cluster that you can take on and try to work with
20 as one essential problem.

21 So there are two models that we
22 need to work with. If we're looking at two-thirds
23 to three-quarters of our dollars being related to
24 these diseases, why are we not dealing with this?

25 Dr. Nighswander kept talking, in

1 Commonwealth North, about the fact that it's the
2 will to change. How do you get people to make
3 these changes? That's the problem. You actually
4 have two excellent models in this state that
5 address this from both angles that can work with
6 that will to change and do something about it.

7 I can't tell you a great deal
8 about the first one today. I can do that later if
9 you'd like. But if you look to Providence Hospital
10 for a preventive model that's evidence-based where
11 they are looking at outcomes, it's about as
12 letter-perfect as you can get, and it's the only
13 one in their particular system. I had an
14 opportunity to sit through an evaluation of that
15 recently. There's some qualitative data they need
16 to add to it, but it's the right design.

17 Now, the advantage of that is
18 that's a good long-term approach, and that's what
19 we should be doing. The disadvantage is that it
20 takes longer to get those things up and running,
21 because you have to make a cultural change. And
22 the cultural changes there have to be made sort of
23 at the employer level. That's the way Providence
24 is doing it. So you'd have to get your employers
25 together and get them to move forward to make that

1 one.

2 If you look at what I'm going to
3 talk about mostly today, and which is my specialty,
4 it has to do with behavioral medicine and the
5 treatment of chronic disease. "Behavioral health"
6 refers to prevention and working with people --
7 maybe they're a little sick, but they're not, you
8 know, terribly sick. "Behavioral medicine" --
9 we're talking about taking on the diseases. They
10 are there. They are serious. People are living
11 with them. They're impacting their life and their
12 health care dollars. That is what I specialize in.

13 And if you look at this more
14 specifically, even, this is also what we call
15 personalized medicine, but it's evidence-based. So
16 the advantage to dealing with chronic disease is
17 you actually have a more willing population, more
18 willing to change.

19 The challenge is that they feel
20 overwhelmed. And so even though they want to
21 change, because they know their life can be on the
22 line, they don't really know how to begin. They
23 are dealing with a disease, and that's sort of
24 taking the will from them. But if you work with
25 that population, and you design a program that

1 empowers them, gives them the right information,
2 and then is also culturally adapted and respectful,
3 you can make significant changes.

4 For six years I have been
5 designing and implementing in this state, with the
6 funding of the National Institutes of Health and
7 with the assistance of MD Anderson Cancer Center, a
8 model which specifically addresses cancer with that
9 model. I'm happy to tell you today I just got the
10 results of our Phase II clinical trial. We have
11 clinically and statistically significant outcomes
12 on all measures. And this is working with people
13 with cancer from zero to stage four.

14 I've also done research with this
15 model for asthma, published with that; clinically
16 and statistically different and positive outcomes.
17 I've designed models for cardiovascular and have
18 looked at some for diabetes but haven't yet done
19 them.

20 This is what you have in your
21 state. You have a good model for preventive at
22 Providence. You have a good model which has been
23 tested here and found to be culturally adapted for
24 an Alaskan population, and this was done at Alaska
25 Regional Hospital. They have supported this

1 research for seven years with resources, asking
2 nothing in return.

3 So just as we finished this and we
4 got ready to go forth, we decided, okay, we need to
5 test this model. And Alaska Regional Hospital
6 brought in Wells Fargo and brought in the
7 Department of Administration, had me present the
8 research, had it vetted. The decision was made to
9 implement it and to let retirees and employees be
10 the model that we looked at.

11 Unfortunately, when the election
12 came, there was great turnover. And so I have now
13 presented this model, had it vetted three times,
14 and had it fall through the cracks. There is no
15 implementation.

16 I also want to point out something
17 else that's important to understand.
18 Evidence-based medicine is critically important.
19 You have to do this. But it's not enough. You can
20 have a good clinical trial that shows that, in
21 fact, it's quite effective; but evidence does not
22 guarantee effectiveness. Evidence is it looks good
23 in clinical trial. You put it in the real world,
24 and half of the time it fails anyway. And why did
25 it fail? They did not adapt it to the culture.

1 They did not look at the exact population they
2 really needed to work with.

3 So even if you had the best
4 clinically tested, most evidence-based trial in the
5 world, you still have to put it into action in the
6 real world, test it, finesse it, and move forward.
7 That's what we've been trying to do for six months.
8 For six months it has fallen through the cracks.
9 No one's fault. People go.

10 The fourth time I explained this
11 program to someone at the Department of
12 Administration and they disappeared within 72
13 hours, I started beginning to feel like I was a bit
14 of a curse, you know. So I hope the poor man, Jim
15 Puckett, who I met with yesterday, who again said,
16 "I've got to recommend that we go forth and do
17 this," I hope he's here in three days.

18 So I guess I wanted to know that
19 you'd be aware of this. And also my mentor and the
20 quality control monitor for this study, Dr. Lorenzo
21 Cohen, who is the Director of Integrated Medicine
22 at MD Anderson Cancer Center -- he said to me two
23 days ago, "Do the people in your state have any
24 idea of the opportunity they have, a program that's
25 been created and defined for them, a program which

1 allows them to, if they want to, set the standard
2 for how to do this?"

3 That was his view, because we have
4 a small enough population that you can actually
5 bite off a chunk and take a look at it.

6 So I think that's the thing that's
7 important to know. And also I'm mindful of the
8 fact, Valerie, you said, "What points do we take
9 away from this?" And I think that's well said. So
10 I think there's a few points here.

11 You have a program which has been
12 tested and assessed over a six-year period that's
13 already been created, evaluated, and made to work
14 for this population; even to the point of it being
15 able to be delivered at a distance, whether that
16 person is in their home with nothing but a computer
17 in front of them, whether they are in a classroom,
18 or whether we have a group where you have to have
19 the instructor on videoconference.

20 The Tribal Health Consortium was
21 critical in helping us get our funding and work
22 with the technology side. I even tested the
23 distant delivery against the live model; and I
24 hypothesized that both would be good, but we'd see
25 a bigger difference with the live model. Well, in

1 fact, that's the only way I was wrong, and I'm sort
2 of glad. We got just as good outcomes at a
3 distance as we did in person. But we did have
4 complaints, because people wanted the instructor in
5 the room. So they had a preference, but the
6 outcomes were just as good.

7 So we need to look at that. We
8 need to take a look at the fact that we're
9 approaching that cliff I hear everyone talk about.
10 And chronic disease is where the biggest amount of
11 your health care dollars go. If you have a chance
12 of surviving this and buying time, you'd best be
13 biting off from that apple and working on that
14 first.

15 That's your first priority. Take
16 that on. Buy yourself some time with reducing the
17 health care dollars. Then invest your time
18 secondarily to the preventive side. It takes
19 longer, but that's where we all really need to be
20 going.

21 You have this program here. It
22 has not been implemented just because of political
23 change. And I think I have many skills, but
24 dealing with politics is not one of them. So it
25 will fall to this body to figure out how to deal

1 with that part.

2 And the fourth point I would say,
3 it's important to take action. If we wait for the
4 perfect program that everybody has vetted, that
5 looks just right, that's going to work, maybe we
6 can all just fall off that cliff like the lemmings
7 to the sea. Or Alaska can do what it does best:
8 Step up to the plate, show courage, take action,
9 implement, improve, and move forward.

10 So this is what I would like to
11 share with you, and I'd like to recommend that we
12 step away from the cliff.

13 Questions?

14 CHAIRMAN HURLBURT: Any questions?

15 DR. LAUFER: I think this sounds
16 fantastic. This is what I would see as the right
17 direction. The program you're trying to implement,
18 is this for cancer patients or obesity or diabetes
19 or --

20 DR. FREEMAN: When you do
21 behavioral medicine, the techniques, the strategies
22 you use are pretty significantly the same across.

23 DR. LAUFER: Across.

24 DR. FREEMAN: But you have certain
25 components. In this model, the educational side

1 about the disease changes out, depending on what
2 you're dealing with.

3 DR. LAUFER: Okay.

4 DR. FREEMAN: And, for example,
5 with the cancer, because we have significant
6 cognitive deficits because of chemotherapy -- I
7 mean, this is the number-one thing.

8 DR. LAUFER: Chemo brain.

9 DR. FREEMAN: Oh, I have some
10 really sick people, and we could see it.

11 DR. LAUFER: Yeah.

12 DR. FREEMAN: And yet we improve
13 their memory and refire their neural pathways. So
14 that one is the hardest. So that's why I chose that
15 first.

16 By comparison, cardiovascular
17 disease and diabetes are a walk in the park. They
18 take half the time, half the money.

19 DR. LAUFER: And I think people are
20 more literate in that, because it's being discussed
21 in the culture more.

22 DR. FREEMAN: Yes. Yes.

23 DR. LAUFER: So if this is
24 implemented -- and we take care of lots of Wells
25 Fargo people --

1 DR. FREEMAN: Yes.

2 DR. LAUFER: -- what would I hear,
3 as a primary care doc? How will I know that you've
4 got approval?

5 DR. FREEMAN: Well, you know, it's
6 like when you do a clinical trial, except now it's
7 effective, is you got to pick a population and
8 start.

9 DR. LAUFER: Right.

10 DR. FREEMAN: And so because Wells
11 Fargo was interested in doing this at Alaska
12 Regional -- it was like employees and retirees --
13 they actually had the letters to notify every
14 employee and every retiree ready to go. You hit the
15 button and you send the e-mail. It was stopped.

16 DR. LAUFER: We see lots of them.

17 DR. FREEMAN: Yeah.

18 DR. LAUFER: Lots and lots of their
19 employees --

20 DR. FREEMAN: But this has an ICD 9
21 code attached to every person that you want to work
22 with. You can find them.

23 DR. LAUFER: So it would be great
24 to have, you know, a letter: This is a go, and
25 here's the code. Because I would wholeheartedly

1 encourage this. I mean, I would spend time to help.

2 DR. FREEMAN: I don't know what
3 else I can do to make that happen.

4 DR. LAUFER: The other question I
5 have is a little bit harder, but this idea of -- to
6 me, evidence-based medicine and personalized
7 medicine are almost, you know, opposites. Where do
8 you get the evidence for that? Is there a source?

9 DR. FREEMAN: I love this
10 discussion. This is a two-hour discussion.
11 However, evidence-based medicine means that you have
12 the consistency of a process that you deliver that
13 impacts people. Personalized medicine means that
14 you add in the consults. Now, this is in
15 relationship to what I'm doing, where you take this
16 now. You look at exactly what's happening in their
17 life and how they're feeling, and you tweak it for
18 their life.

19 We even have a spiritual component
20 in here, and I've had it tested across about every
21 religious tradition you can think. We've had
22 everything from Alaska Native elders, Yupik elders
23 who went through this and found it completely
24 respectful of their culture, all the way to
25 biochemical researchers who only wanted to see the

1 facts, ma'am. And we can do all of that and work
2 it within this model.

3 DR. LAUFER: A personalized
4 application of population-based evidence?

5 DR. FREEMAN: Yes.

6 DR. LAUFER: That makes sense.

7 DR. FREEMAN: Yes. In other words,
8 what you're teaching them in layman's terms but
9 simple language is what they need to know to do it.
10 And then they practice. And in between each class,
11 they have a one-on-one consult with the behavioral
12 person who works for them. "How are you feeling?
13 What's going on? What are you struggling with?"

14 Because what happens is they can
15 sort of know how to do it, but you get stuck. And
16 you have to be willing to speak the language of
17 that person.

18 DR. LAUFER: Or be capable of it.
19 Yeah.

20 DR. FREEMAN: Exactly. And that's
21 the special skill to go along with the science.
22 You've got to have both. So the people that offer
23 this are all certified by me and trained.

24 DR. LAUFER: How much more
25 resource-intensive is this, do you think, than the

1 haphazard approach that's been taken so far? You
2 have, obviously, counselors. Do you have diabetic
3 educators or --

4 DR. FREEMAN: Well, we have
5 behavioral medicine specialists. And right now I
6 have three people. There's three of us that are
7 available. And the bottom line to this is the
8 science part can be standardized so much that you
9 don't have to be an expert in that.

10 DR. LAUFER: Yeah.

11 DR. FREEMAN: You have to have the
12 skills to do the personalized side. Nothing can be
13 geared up when no one is agreeing to do this. And
14 we actually had it set up to begin the first
15 training in January. So now we've lost, you know,
16 based from the time we started, six months, really,
17 from the time we started; and in reality, a year,
18 because you don't start anything in the summer in
19 Alaska. You just don't do that.

20 DR. LAUFER: You're fortunate in
21 that the problem is not going to go away or get any
22 less urgent. It will be here.

23 DR. FREEMAN: I would love to be
24 out of a job because there was no need. That's not
25 the issue; the issue is getting people to

1 understand. I think people believe that behavioral
2 change is so impossible, they just sort of say, "You
3 know, that's really what we ought to be able to do,
4 that isn't going to work."

5 Well, we've demonstrated it can.

6 DR. LAUFER: It's not impossible at
7 all.

8 DR. FREEMAN: No.

9 DR. LAUFER: Maybe people with
10 personality disorders or brain injuries; but most
11 people can change.

12 DR. FREEMAN: Yes, of course. But
13 they need the right perception, motivation,
14 information, and support.

15 DR. LAUFER: The narrative of their
16 life.

17 MS. ENNIS: I have a question again
18 about the workforce. You said you used behavioral
19 medicine specialists?

20 DR. FREEMAN: Yes.

21 MS. ENNIS: And where do they come
22 from? What training do they need to get?

23 DR. FREEMAN: They are certified by
24 me --

25 MS. ENNIS: Okay.

1 DR. FREEMAN: -- because this
2 specific approach is very specialized. And just
3 having the degree doesn't do it for you. A lot of
4 times the best people for me to train up -- you
5 know, because keep in mind what we're moving towards
6 now -- I guess I didn't explain this part. We're
7 now taking the scientific training parts that I do
8 and we're professionally videotaping them and
9 preparing them to stream. We're in usability
10 testing for that.

11 So I will be able to train
12 facilitators who can use this. They don't have to
13 have the expertise absolutely. They can use this
14 for the educational side. But they know how to do
15 the exercises, how to facilitate, and how to bring
16 that back to the person.

17 So, to be real honest with you, I
18 mean, I worked with the university here for a
19 while. I wrote grants for them before. I could
20 not get the support I needed. So I had to go and
21 literally open up my own grant agency and write
22 these from scratch, because I could not get others
23 to envision what we were speaking of. And this is
24 seven years later, and I'm still not sure I have
25 people -- but we have seven articles that we are

1 drafting now for publication.

2 MS. ENNIS: Thank you.

3 CHAIRMAN HURLBURT: Lyn, thank you
4 very much. We appreciate your bringing that to us
5 and sharing it with us.

6 I'd like to check -- anybody else
7 on line now who would like to testify? Okay. And
8 nobody else from the audience.

9 I think what we'll do, with the
10 time of year that we're in, a lot of folks are on
11 the short strings, and Linda's short string got --

12 MS. HALL: Shorter.

13 CHAIRMAN HURLBURT: -- jerked, and
14 she now needs to leave at 2:30. So I think what we
15 will do is go ahead and move to what we have
16 scheduled for 3:30 for Linda and for me for an
17 update.

18

19 UPDATE ON RELATED INITIATIVES

20 AFFORDABLE CARE ACT

21

22 CHAIRMAN HURLBURT: And this was
23 where questions were raised, again. This came out
24 of the last meeting, but it's an update on the
25 Medicaid Task Force and on what the state has been

1 doing related to the Pension Protection and
2 Affordable Care Act. It's kind of a status
3 report -- not looking for direction or policy
4 decisions, but kind of a status report on, one, what
5 the Medicaid Task Force is doing, which is scheduled
6 to have its last meeting next week here in Juneau,
7 and we'll have a set of recommendations; and then
8 also where we are related to the Affordable Care
9 Act.

10 So, Linda, if you could go first,
11 then, and you're okay until 2:30, as I understand.
12 Is that right?

13 MS. HALL: Well, I need to be in
14 Senate Labor and Commerce at 2:30.

15 CHAIRMAN HURLBURT: You have to be
16 there at 2:30?

17 MS. HALL: Yes.

18 CHAIRMAN HURLBURT: So you're --

19 MS. HALL: But I'm fine. I mean, I
20 don't have a whole lot to say, so it's fine.

21 CHAIRMAN HURLBURT: Okay.

22 MS. HALL: But I do appreciate you
23 moving the agenda around. I did not realize this
24 bill had a hearing today until I was walking down
25 the street, and lo and behold.

1 So, with that, I would just really
2 like to -- I know, as a result of the last meeting,
3 there's some questions -- do a little bit of update
4 on PPACA, where we are as a state. Probably most
5 of you know where we are. You've read the
6 headlines in the paper.

7 We have a high-risk pool. We call
8 it ACHIA-Fed. Our long-time, statutory, high-risk
9 pool took on the contract to do the federally
10 funded high-risk pool, and that was effective
11 July 1 of last year. And you may or may not have
12 read this. These high-risk pools were implemented
13 to provide people a place to go that didn't have
14 insurance so that -- they were unable to purchase
15 insurance because of some type of preexisting
16 condition.

17 So about half the states accepted
18 federal money; and then in the other half of the
19 states, the feds actually implemented themselves
20 some type of high-risk pool.

21 This week we have 34 people in our
22 high-risk pool. We've spent of lot of time getting
23 a high-risk pool up and running to only have 34
24 people, but it's expensive. The money is strictly
25 federally funded, but it's still expensive at

1 100 percent of the average health insurance
2 premium. So while the statutory pool can go up to
3 140 percent of standard premium -- it's not there
4 right now -- this an average premium, and I think
5 it's still unaffordable.

6 So we have 34 people enrolled
7 today. I participated in a phone call this week
8 with Health and Human Services and our high-risk
9 pool administrators, and they're estimating that we
10 might have 88 people by the end of the year. When
11 we did the -- we didn't do them. It was all
12 outsourced -- but there were actuaries who did a
13 projection based on the amount of money that was
14 allocated to our state, which was \$13 million, for
15 this pool. Our estimate was that we could probably
16 fund, over the full period until January 1 of 2014,
17 about 110 people. It's not a lot. So you get some
18 idea of what health care costs are for people with
19 serious health conditions when \$13 million will
20 only fund 110 people.

21 But anyway, that's the status on
22 the high-risk pool. It is operating. And for
23 people who need it, I think it's a great thing. I
24 would just throw in, just as information, our
25 statutory high-risk pool runs around 500 people,

1 maybe a little more. It depends. It will go up
2 and down some. But that is funded by the insurance
3 industry. It's an assessment that is made on our
4 insurers. And today a portion of that is funded
5 through general funds, because there is a premium
6 tax credit available. But both of these pools
7 serve -- Jeff chairs the statutory pools.

8 So I guess you chair both of them,
9 in reality.

10 MR. DAVIS: I do. Double my work
11 and double my pay.

12 MS. HALL: Yeah. You know, double
13 of nothing is good.

14 But any rate, I think -- while
15 sometimes I think it was a lot of work to put
16 together for that number of people, those people
17 really needed insurance coverage and weren't able
18 to find it in the standard market.

19 The other thing I'd report on is
20 the status of what we call market reforms. On
21 September 23rd, PPACA required most insurance --
22 there are a number of exceptions for grandfathered
23 pools, and some things don't apply to self-insured
24 groups, so it gets very complicated.

25 But for the most part, we had a

1 number of things that went into effect
2 September 23rd. That's when the federal law went
3 into effect; but the coverages, the market reforms,
4 actually are implemented as each insurance plan
5 renews.

6 For example, most individual plans
7 renew January 1. That's just the date that a lot
8 of them renew. But small-group plans renew at
9 various times, so that the first renewal after the
10 September 23rd date is when most of the market
11 reforms go into being -- those are things like
12 there is no longer a lifetime maximum. Most
13 policies had some kind of -- \$1 million, \$2
14 million, whatever it might be. Those go away.
15 Annual maximums are being phased out also.

16 All of a sudden I'm drawing a
17 blank, Deb, about the rest of the market reforms.
18 That's where the up to age 26 -- which has been
19 highly controversial with our retirees -- but up to
20 age 26 goes into effect, where your dependent -- I
21 guess they don't even have to be dependent --
22 children can still be covered under an adult's
23 policy.

24 So we have a number of things that
25 are in effect by federal law. And so our insurers

1 who operate -- and they all do in multiple
2 states -- will implement those as they are
3 effective.

4 I would talk just briefly about
5 the health insurance exchange. Alaska, as I think
6 we all know, did not apply for the federal planning
7 grant. There was a real reluctance to become
8 entangled in the federal law; and we are in
9 litigation with the federal government over this
10 particular law, as you well know.

11 But right now, as that law has
12 been stayed in our lawsuit -- I think that's the
13 right term -- we're implementing the things that
14 we're required to implement.

15 So we're looking -- the Department
16 of Health & Social Services and the Division of
17 Insurance are working together in a planning stage.
18 We're doing that with our internal resources, and
19 doing -- we are in an analysis stage. We're not
20 prepared at this point to discuss need or
21 direction, or need for potential legislation, even.
22 So we are analyzing.

23 There is a lot of work going on
24 across the country, and I just came back from a
25 meeting last weekend where I sit on a National

1 Association of Insurance Commissioners Exchange
2 Working Group; and I listened to both testimony
3 from the public, and I listened to what my
4 counterparts around the country are doing.

5 There are some grants that were
6 given to a group in New England. There were
7 supposed to be five, and I think they ended up
8 doing seven -- called Early Innovator Grants, where
9 people are developing IT systems.

10 So we're looking at what they're
11 doing. There is, in my mind, no need to double the
12 work that people are doing. There is a lot of
13 duplication. There's a lot of money being spent on
14 implementation, and so -- but we are looking at
15 that, looking at what Alaska needs.

16 And I'm actually going to look at
17 these so I make sure I get them right. The
18 principles that will guide us in creating an
19 exchange: maximize Alaskans' freedom and privacy,
20 minimize federal entanglement, and foster
21 citizen-based choices.

22 So those are like the guiding
23 principles, but we're doing an analysis of --
24 obviously, Massachusetts has a track record of
25 having an exchange. Utah has an exchange, a very

1 different kind exchange. What would work for
2 Alaskans? What would we need?

3 So generally I'm working with
4 Health & Social Services to do some analysis, to
5 put together what we think would be best before we
6 proceed to do next steps, whatever those may turn
7 out to be.

8 And I'll stop rambling now. Thank
9 you.

10 CHAIRMAN HURLBURT: Any questions
11 for Linda? Yes?

12 MS. HALL: I could see who it was
13 going to be from --

14 REPRESENTATIVE KELLER: No.
15 Actually, first, thanks. Linda is one that we
16 really appreciate up there, and she's a reference
17 point for us and is very important.

18 MS. BARKER: Can you speak more
19 into the microphone, please?

20 REPRESENTATIVE KELLER: Sure. It
21 was just words of appreciation for Linda. I
22 appreciate her and respect her help in the
23 Legislature.

24 Just a clarification. Did you say
25 that this requirement up to age 26 is not -- the

1 child doesn't have to be a dependent? Did I hear
2 you say that, or not?

3 MS. HALL: Well, you heard me say
4 it, but I'm not sure, now that you question me. It
5 doesn't, Deb. Yeah. It doesn't. You do not have
6 to be a dependent.

7 REPRESENTATIVE KELLER: Okay.

8 MS. HALL: Where it used to be like
9 your child had to be in college and those types of
10 things. Okay. Thank you.

11 CHAIRMAN HURLBURT: Yes?

12 MR. DAVIS: Linda, if I could just
13 add one thing, because I was watching the raised
14 eyebrows of the \$13 million subsidy going for 100
15 people for three years.

16 The regular ACHIA that Director
17 Hall was talking about with 500 people, the annual
18 subsidy -- so people are paying premiums at
19 130 percent of market -- the annual subsidy is
20 between \$8 and \$10 million for those 500 people.
21 So that just kind of gives you an idea of the
22 magnitude of what we're dealing with.

23 But it's a program that works, I
24 will add. It's a public policy that carries out
25 its objective, which was to make sure that anyone

1 who wanted to and could afford to in Alaska could
2 buy a health insurance policy, regardless of their
3 health status. I'm proud to be a part of that.

4 CHAIRMAN HURLBURT: Yes, Keith?

5 MR. CAMPBELL: That \$8 to \$10
6 million for those 500 people, that comes out of the
7 2 percent premium, or whatever the premium is now on
8 the thing? Or general tax revenue?

9 MR. DAVIS: No. It's -- well, I'll
10 give you the long answer.

11 It's initially an assessment on
12 the insurers who do business in this market,
13 selling medical products. But it's only on insured
14 business. So if you have a self-funded employer,
15 that's not counted as part of it. So you look at
16 insured market share, and it just gets divvied up
17 based on your percentage of market.

18 It then, of course -- at least, I
19 think, in our case. I'll speak for us -- gets
20 translated into a per-member-per-month cost, which
21 then gets added into the premium. So it's
22 essentially a tax on everyone who has insurance to
23 pay for the pool.

24 I forget exactly when it came into
25 play. I think I want to say about three years ago.

1 Representative Rokeberg had sponsored legislation
2 that created a premium tax credit, a retrospective
3 tax credit, against an insurer's allocation. So if
4 ours was \$5 million, then we'd get a credit for
5 50 percent, a \$2.5 million credit to be taken in
6 the next year. So essentially it converts -- by
7 forfeiting that revenue, in the following years it
8 converts the funding to general fund revenues, is
9 the way I look at it.

10 CHAIRMAN HURLBURT: Yes, Paul?

11 COL. FRIEDRICHS: Thank you,
12 Mr. Chairman.

13 So living in a very different
14 world on the federal side and then thinking back to
15 the admonition to stay at the 50,000-foot view and
16 think about our report due in January, if this goes
17 away in 2014, what should -- or should we, in any
18 way, address what to do about these patients beyond
19 2014? And where do you see this fitting into that
20 continuum of health care that we spoke about?

21 MS. HALL: Do you want to talk, or
22 do you want me to talk?

23 MR. DAVIS: Go ahead.

24 MS. HALL: Okay. I don't -- we can
25 both talk. We both do.

1 Those patients today, or those
2 members of the high-risk pool, whether it's the
3 statutory high-risk pool or the federally funded
4 pool, will be eligible for coverage in the
5 traditional marketplace. The ability to exclude
6 someone from buying health insurance because of a
7 preexisting condition goes away. It will be
8 prohibited to have that type of a condition -- of
9 an exclusion.

10 So those people that today are
11 members of the high-risk pool will be blended in
12 with the rest of the population. And so we will be
13 adding those individuals with high-cost health
14 conditions that, in certain circumstances, in the
15 individual market are not eligible for coverage.

16 In the small-group market there is
17 a different dynamic, and they are eligible for
18 coverage in the small-group market if they are
19 employed and their employer buys a group policy.
20 There's a lot of things around that, so that's a
21 very broad statement. But the need to have a
22 high-risk pool, at least in theory right now, will
23 evaporate.

24 COL. FRIEDRICHS: And I guess, if I
25 may, Mr. Chair, follow up on that.

1 That was sort of what I was
2 leading to, the "in theory" part. You know,
3 just -- as with so many other programs along the
4 way, as we look at long-term best interest for
5 health care in Alaska, we know that we have this
6 very expensive subset of our population. So our
7 assumption is, if I understand correctly, that
8 indeed PPACA is going to be implemented, and our
9 planning and our recommendations are all based on
10 that assumption that all these high-risk patients
11 will be blended into the general population, and
12 that this is all going to come to fruition,
13 regardless of the suit.

14 Is that a correct understanding?

15 MS. HALL: Well, it depends on the
16 outcome of the suit. If the PPACA is found to be
17 unconstitutional, if that's a successful suit, then
18 there will be a different climate, so to speak. And
19 I don't know that we would or would not implement
20 PPACA.

21 CHAIRMAN HURLBURT: I think you'd
22 have to say that, in Alaska, the assumption is that
23 PPACA will be found to be unconstitutional. That's
24 based on the advice from the Attorney General to the
25 Governor, and so that's the position of the state.

1 A new item this morning, where
2 Virginia, as you know, has a different suit -- they
3 are not participating with the other 28 or whatever
4 the number of states is now -- their Attorney
5 General Cuccinelli made a guess that they would
6 have a 60 percent chance of prevailing in their
7 suit at the Supreme Court level, which sounds to me
8 like it's kind of modest for an attorney. Usually
9 an attorney will go in and say, "We've got a
10 120 percent chance of winning," so he must have
11 some reasonable doubts that they'll prevail.

12 But I think that the modus
13 operandi in Alaska is the assumption that it is an
14 unconstitutional law, and that those who are
15 challenging the law, led by Florida, will prevail.
16 So, personally you may or may not agree with that,
17 but as far as the state-level operation, it is that
18 it's unconstitutional. Although, based on the
19 judge's decision at the district court level,
20 before it goes to the appeals level, while he found
21 the mandatory coverage provision unconstitutional,
22 he didn't vacate the whole law. He didn't put a
23 stay on the whole law.

24 So the things that we have to
25 comply with, we are complying with. But where

1 there is not a mandate, then we're acting as if we
2 will prevail on that challenge.

3 COL. FRIEDRICHS: So as, perhaps,
4 the dim bulb on God's front porch here, our charge
5 this morning from Senator Olson was to be specific
6 and to bring forward measurable programs.

7 This sounds like this is a very
8 specific, very measurable program which, Jeff, I
9 believe you said was a successful program. Do we,
10 as a commission, have an obligation to comment on
11 specific measurable successful programs and say
12 that this is something that has worked?

13 I mean, if we've got patients that
14 we know are high risk and very expensive, and we've
15 done something that helps to take care of them,
16 should we, as a commission, include that in our
17 series of observations and recommendations that we
18 make so that, regardless of what happens with
19 PPACA, we don't lose something that is successful
20 in helping patients?

21 CHAIRMAN HURLBURT: Jeff?

22 MR. DAVIS: We may want to do that.
23 This is a really interesting situation. I'm a
24 back-of-the-envelope lawyer, is all I can claim.
25 But as I understand it, the lawsuit that Alaska is

1 party to, when that was decided the way it was, it
2 means that Alaska and the 28 other states themselves
3 are the ones who are the beneficiaries of that
4 decision.

5 However, an insurer working in
6 Alaska or those 28 other states is not a party to
7 that lawsuit and, therefore, has the obligation to
8 continue to implement all the pieces of it. So
9 that's one interesting dynamic.

10 The other thing that is
11 interesting in this is -- and I'm going to
12 oversimplify, so forgive me. One of the things
13 that is in the state's -- was in the state's
14 purview to do was the creation of the exchange.
15 And so those 29 states, including Alaska, could
16 say, "We're not going to do that."

17 However, if -- by December of
18 2012, states have to report to HSS nationally their
19 progress towards creating an exchange. And if you
20 haven't made sufficient progress, you get a federal
21 exchange. So just not doing it doesn't mean you
22 dodge the need to have an exchange; it means it gets
23 done to you rather than doing it yourself.

24 Which leads me to the real point
25 of this, which is in thinking about the principles

1 that Director Hall laid out, and thinking from an
2 insurer's point of view who is dedicated to seeing
3 that we have a sustainable individual and
4 small-group market -- because that's what PPACA
5 impacts in 2014 -- there are some fundamental risk
6 factors, risk-bearing factors in PPACA that don't
7 work.

8 It is -- guaranteed issue is the
9 equivalent of being able to call up your homeowners
10 insurance and say, "My house is already on fire.
11 Can I buy a policy?" Okay. That's not -- everyone
12 can recognize that's not a financially sustainable
13 model. Calling and getting a policy when you've
14 just been told you need open-heart surgery next
15 month, when your policy is effective, is also not a
16 financially sustainable model.

17 So there has to -- so
18 guaranteed -- excuse me. The antidote to
19 guaranteed issue was the mandate. If everybody is
20 in the pool, then you can make this work. But if
21 people can opt out, and there is not much of a
22 penalty, then that doesn't work. So you have to --
23 to have a viable individual and small-group market,
24 there have to be other mechanisms put in place that
25 offset the financial reality of guaranteed issue.

1 Most of that rule-making, I
2 believe -- and it bears to be seen -- will happen
3 in the state exchange, because there are so many
4 things that are not explicit in PPACA that it's
5 left to kind of the state's discretion to deal with
6 those.

7 So I applaud the efforts that
8 Dr. Hall described to move forward with the
9 planning; and I think it is -- to your question,
10 Paul -- it is at that point I think that Alaskans
11 will have to say, "Okay. Is there a continued role
12 for ACHIA? Has that become our risk-spreading
13 mechanism in some manner?"

14 And from here, we just diverge
15 into weaving scenarios that could be possible, but
16 that's a dialogue that we all need to participate
17 in over the next -- maybe not as commission
18 members, but in our own individual roles over the
19 next couple of years to work that out so that we do
20 have a viable and sustainable small-group market.

21 CHAIRMAN HURLBURT: Keith?

22 MR. CAMPBELL: Following that
23 discussion, it seems to me, then, at the 50,000-foot
24 level, then we ought to be discussing whether that
25 should go into our recommendation, that ACHIA --

1 depending on the success or not success of the
2 lawsuit issue, of whether things go away in 2014 --
3 if we think that ACHIA is a viable model, then we
4 ought to be recommending to the policy-makers that
5 that continue, and we don't have to get into the
6 details, I would think. But if we do think that, we
7 ought to be thinking over the next couple of years
8 of how we make that recommendation to the
9 Legislature and the Governor, rather than just have
10 it drop off the table at X date.

11 CHAIRMAN HURLBURT: Paul?

12 COL. FRIEDRICH: And I apologize
13 for belaboring this, but I go back to my time in
14 D.C. There are very few programs that have worked
15 for this high-risk population. We've tried all
16 sorts of things on the federal side, that I've been
17 involved in, to figure out how to do this well.

18 If this is actually impacting what
19 specifically our commission was charged to do --
20 which is improve access, develop a sustainable
21 model -- and by "sustainable," from a resourcing
22 standpoint that means I know how much it will cost
23 me and what I will get for what I'm paying, and I
24 commit to paying that amount -- that's remarkable.
25 I mean, that is the first time in years that we

1 have got something that we can point to to say,
2 "This is really working for one of our largest --
3 small numbers, largest utilizer population."

4 And I would encourage the
5 commission to consider how we capture that and not
6 let this fall through the cracks of all of the
7 political discussions that are happening around it.

8 You know, Mr. Chairman, from your
9 much greater experience than mine in this, we've
10 talked about how to help the high utilizers for
11 decades. This goes back to even the '60s and the
12 discussions on what Medicare would look like and
13 how to help them.

14 If we've got something that's
15 working here, how do we articulate clearly that
16 this has worked for these patients and ensure that
17 it doesn't get lost in all the other discussions
18 that are happening?

19 CHAIRMAN HURLBURT: Deb?

20 MS. ERICKSON: Can I just ask a
21 clarification on the issue we're discussing right
22 now? There is nothing about the Affordable Care Act
23 or anything else that is going to cause our state
24 law related to our state high-risk pool to go away.
25 It's just that there is -- presumably there won't be

1 a need for a high-risk pool. I'm looking at our two
2 insurance experts. Okay.

3 So we're not -- I don't think
4 there is a risk that we're going to lose the
5 state's law and the state's high-risk pool,
6 regardless of what happens with the lawsuit and the
7 Affordable Care Act. The state would have to
8 actively -- the State Legislature would have to
9 repeal that law, actively repeal the law because --
10 based on some finding that it was not necessary
11 anymore.

12 So I wanted to make sure I
13 understood that correctly, and they are nodding
14 their heads, our insurance experts. So I wanted to
15 just make that clarification.

16 And then Noah had his hand up
17 next, and then I think Keith.

18 DR. LAUFER: This gets back to this
19 question of what is health care, you know, what is
20 health. And to me, from the doctor point of view,
21 these patients with ACHIA or not, regardless of
22 whether they are insured or not, they still show up
23 having heart attacks. They still are in the ER.
24 They are still having cancer. Their outcome is
25 really not changed by this. This is a debate over

1 whether we force the private insurance company to
2 take on risks that they wouldn't, based on their
3 risk management, and they pass it on as an
4 additional tax to people who are already paying, or
5 the feds pay.

6 And I think the revolutionary
7 change is to do a better job at medical care, not
8 to argue over who is going to pay for it or who
9 isn't. It's a very nice form of cost shifting,
10 which I think is -- it's great, because it has to
11 happen. But you still haven't addressed the
12 question of are people healthy or not.

13 And, you know, I suppose it
14 improves access. What it does is it allows people
15 to get access with lower acuity, perhaps; but they
16 are not healthier. You know what I mean? I know
17 it's politically really an important issue, but if
18 the impact is on individual people and their
19 health, that's not the issue.

20 CHAIRMAN HURLBURT: Keith?

21 MR. CAMPBELL: Well, I guess I was
22 concerned about the ones that are covered under the
23 federal subsidy at this point in time, not losing
24 those people at X -- in 2014 or something like that.

25 COL. FRIEDRICH: And that was my

1 point also, that if that federal money is going away
2 in 2014, what happens --

3 MS. HALL: Those people that are
4 covered under the federally funded high-risk pool
5 for roughly the same premium -- because they are
6 being charged 100 percent of the standard premium --
7 should be able to purchase insurance in the standard
8 market because of the prohibition of an exclusion
9 for preexisting conditions. So it shouldn't cost
10 them significantly different.

11 And that high-risk pool, federally
12 funded, is a significantly high premium. If you go
13 on the website and look at the premiums for various
14 states -- and that's based on health care costs
15 here, so I think we're really back to your
16 question. Are we making them healthier? It's a
17 funding mechanism, but they will be able to
18 purchase coverage in a different marketplace, so to
19 speak.

20 CHAIRMAN HURLBURT: Anything else
21 on that?

22 So was everybody clear from what
23 Linda said on where we are going as a state,
24 related to the health insurances exchanges, where
25 we really are the odd person out? We're the one

1 out of the 50 that is going a different direction.

2 The Governor has publicly stated,
3 as Linda said, that Linda and the Department of
4 Health & Social Services are working together to
5 plan implementation. Currently it's in the
6 analysis stage.

7 The Governor's stated public
8 position is that we do not need legislation this
9 year to pursue that, and the guiding principles
10 that he's outlined are that we have maximum freedom
11 and privacy for Alaskans, that we minimize federal
12 entanglement, that we foster more citizen-based
13 choices. And the reason for not applying for the
14 federal planning grant is to minimize federal
15 entanglement and obligation on that.

16 In other words, he believes in the
17 golden rule: He who has the gold, rules. And so
18 we're not taking the gold, I guess.

19 And, as Jeff said, he's under the
20 mandate to follow that. And there are other things
21 that are in the law that still stand until there is
22 a decision. There will be increased attention by
23 the feds, and really by a mandate from the feds
24 through the Medicaid program, to more aggressively
25 look for fraud and abuse kinds of issues, which can

1 fall heavily on physicians at times when there is a
2 presumption that everybody is doing the wrong
3 thing.

4 On the other hand, with
5 three-quarters of a million, or whatever the number
6 is, of physicians around the country now and a
7 \$2.75 trillion industry, there is going to be a
8 substantial amount of fraud. As a percent of that
9 whole industry and as a percent of the whole
10 participants, it can be really, really small, but
11 it can still come out to be a long list.

12 And so we've got to be smart
13 enough. Yeah, you don't want to tolerate that.
14 None of us want to tolerate that, but we don't want
15 to tar what is, overall, a very ethical,
16 compassionate, and caring industry with the brush
17 that they are all a bunch of fraudsters and
18 charlatans. So that will be going on. Let me --

19 DR. FRIEDRICH: I believe Val had
20 a question.

21 MS. DAVIDSON: So are you still in
22 Affordable Care Act limitations, before we turn our
23 attention to Medicare?

24 CHAIRMAN HURLBURT: Yeah. We're
25 going to need to wrap this up because we're --

1 MS. HALL: I got to go. Sorry.

2 CHAIRMAN HURLBURT: Yeah. We're
3 scheduled for the technology session, which we want
4 to start at 2:00. So we'll break with this, but
5 then we'll go back to the Medicaid Task Force, and
6 I'll cover that. But go ahead.

7 MS. DAVIDSON: So I guess, just in
8 terms of the Affordable Care Act, I think that one
9 piece that has not come under attack is the fact
10 that, of course, the feds can make changes and
11 requirements about Medicaid, because it's federally
12 authorized and state-implemented.

13 And so we have -- because of the
14 expanded coverage, we're going to have about 50,000
15 to 60,000 people in Alaska who now are going to be
16 eligible for Medicaid. So enrolling that number --
17 one, getting the word out, the outreach required to
18 be able to let folks know that, "Oh, by the way,
19 you might be eligible"; two, the actual enrollment
20 of folks; and then, three, being able to -- to be
21 able to be prepared to be able to absorb everything
22 that's required for dealing with that giant sea
23 change. I mean, that's -- 60,000 people is what --
24 I'm not a math person, but, yeah, it's about
25 10 percent of our population.

1 CHAIRMAN HURLBURT: It's a
2 50 percent increase in the current Medicaid
3 enrollment. There is about 130,000 a year, but a
4 prevalence at any given time is about 110,000 to
5 120,000.

6 MS. DAVIDSON: So regardless of the
7 numbers and the percentages, the impact is going to
8 be significant, and it's coming really quickly. And
9 I don't know that we've had any -- the health
10 exchanges, I mean, it's fascinating. It's
11 interesting. It's unknown.

12 This one is coming. We know what
13 it is. We know what it's going to look like, but I
14 haven't heard any report on what that plan is for
15 how we're going to implement getting the word out,
16 the outreach part, enrolling folks, and then
17 ramping people up to be able to provide that
18 additional care.

19 Because we have folks who, right
20 now, aren't receiving Medicaid services, who may be
21 in a community and they can't get services because
22 Medicaid is what pays for the ticket out to be able
23 to get them the service that they need.

24 So we all, as a state, need to be
25 prepared to deal with that additional -- it's an

1 access issue. It's a whole variety of issues. So
2 that's one.

3 The other piece is that folks also
4 need to be aware that the Indian Health Care
5 Improvement Act Reauthorization was also included
6 as an amendment to the Affordable Care Act. And in
7 terms of questions of -- there are all kinds of
8 questions about severability, et cetera.

9 But I guess the other question I
10 have is that, without the tribal health system out
11 there providing pretty much all of the health care
12 that's available in rural Alaska, if that were to
13 go away or somehow no longer be authorized, we're
14 going to see a huge increase in the general fund
15 for the state to be able to meet their required
16 constitutional mandate to provide health care to
17 Alaskans, because Alaska Natives are Alaskans like
18 everybody else.

19 So I'm not really sure how that
20 sort of all plays in the mix of this conversation
21 about the Affordable Care Act and what the State of
22 Alaska's position is in regard to whether we like
23 it or not; and whether we like all of it, whether
24 we like some of it, what's our plan for
25 implementation.

1 So I haven't heard -- and the
2 exchange is one small, very interesting part of the
3 Affordable Care Act; but, compared to everything
4 else, it's pretty small. So I'm hoping that we'll
5 have -- I'm assuming that was one small part of the
6 Affordable Care Act update. Are you going to
7 provide that or --

8 CHAIRMAN HURLBURT: Yes.

9 MS. DAVIDSON: Okay.

10 CHAIRMAN HURLBURT: Shall we come
11 back to this, Deb?

12 MS. ERICKSON: We should continue
13 it --

14 CHAIRMAN HURLBURT: Because Joe and
15 Andrea are going to be calling in.

16 MS. ERICKSON: -- to our 3:30.

17 CHAIRMAN HURLBURT: Okay.

18 MS. ERICKSON: Dave has a question,
19 but I'm going to go make sure the phone --

20 CHAIRMAN HURLBURT: Yeah.

21 MR. MORGAN: It's not a question.
22 I was wondering if I could be excused. I need to
23 run up on House Bill 78. It's only three minutes of
24 testimony, and then come back.

25 CHAIRMAN HURLBURT: Sure.

1 MR. MORGAN: Thank you.

2
3 HEALTH INFORMATION TECHNOLOGY AND
4 THE HEALTH INFORMATION INFRASTRUCTURE

5
6 CHAIRMAN HURLBURT: Thank you.

7 So the next session again was in
8 response to the discussion last time on health
9 information technology, health information
10 infrastructure. There are a number of things going
11 on. Joe McLaughlin, who is the state
12 epidemiologist and the section chief for the
13 section on epidemiology in Anchorage, is going to
14 be on the phone. And Joe is going to be talking
15 about the use of health information, particularly
16 in a public health setting and in a public health
17 context.

18 Paul Cartland, who is here with
19 us, is the State Health Information Technology
20 Coordinator. And Paul has been the focal person
21 behind a lot of the changes going on in health
22 information technology in the state, things that
23 we've been doing with the health information
24 exchange, the Alaska Health Electronic, whatever it
25 is, technology, NHIN; also, the Medicaid program

1 for \$63 trillion available to physicians; the,
2 whatever is, a million and a half or so to
3 hospitals for implementation of electronic health
4 records systems -- we'll be talking about that. We
5 are not getting into many of the nitty-gritty
6 details, but more of what the role is, what we're
7 doing as a state.

8 And then Andrea Fenaughty, who is
9 the Deputy Chief of our Chronic Disease Prevention
10 and Health Promotion section, will be on primarily
11 to answer questions about how we are using that.
12 Andrea is a doctoral-level person who is very key
13 to a lot of our using data and looking at it from a
14 population standpoint.

15 So, Joe and Andrea, are you on the
16 line now? Not yet. Okay. I think we want to have
17 Joe go first, so we'll --

18 MS. ERICKSON: Well, I was going to
19 go first.

20 CHAIRMAN HURLBURT: You're going to
21 go first? Okay. Thank you.

22 MS. ERICKSON: Just give us a
23 minute while folks get on the phone. And, Ward, you
24 might want to sit off to the side, since we're going
25 to have a couple sets of slides again.

1 We're behind tab 4 now, if that
2 wasn't perfectly clear, while we work out technical
3 difficulties.

4 Dr. McLaughlin, are you on the
5 line?

6 DR. McLAUGHLIN: Yes, I am. Hi,
7 Deb.

8 MS. ERICKSON: It works. Great.
9 And how about Dr. Fenaughty?

10 DR. FENAUGHTY: Yes. I'm right
11 here.

12 MS. ERICKSON: Oh, very good.
13 Thank you both for joining us today.

14 So we're going to go ahead and get
15 started. And, Joe and Andrea, if you're sitting in
16 front of a computer, we're going to go through --
17 we have two different presentations you can access
18 on the Alaska Health Care Commission's website on
19 our March meeting page, if you are interested.

20 But I'm going to start off the
21 session right now just with -- Dr. Hurlburt gave us
22 a little bit of an introduction to this session.
23 I'm just going to take a couple minutes to talk
24 about the purpose for this session and talk a
25 little bit about the concept of expanding our

1 understanding of health information technology,
2 thinking a little bit more broadly about health
3 information and health information infrastructure.

4 And then Joe is going to talk with
5 us a little bit about public health uses of health
6 information and give us some examples of that.

7 And you all have met and heard
8 from Dr. Fenaughty a few times in the past. We're
9 going to be having a follow-up conversation on the
10 online community health information system that
11 we've been learning about as well.

12 And then Paul Cartland, the State
13 Health Information Technology Coordinator for the
14 Department of Health & Social Services, is going to
15 update us on some major initiatives related to
16 health information technology.

17 Just a couple of things as a
18 reminder: One, if you can picture -- I actually
19 have a slide in here, again. The graphic that we
20 have right now of our strategy for health care
21 transformation identifies the major elements of the
22 infrastructure that we need to make sure is in
23 place, the foundation of a strong system. It
24 includes health care workforce, health information
25 technology, and statewide leadership. So if you

1 can just remember -- picture that in your mind.

2 So far the commission's focus on
3 health information technology has been very
4 specific to a big issue -- it's not that it's that
5 specific -- but limited so far to electronic health
6 records, health information exchange, and
7 telemedicine.

8 And we really started expanding
9 our concept of what we're talking about, and the
10 need for health information in the last couple of
11 meetings, as we started hearing about and having a
12 conversation with some of the community leaders
13 around the state who brought forward the problem of
14 not having good access to local health information
15 for making decisions at the community level about
16 health and health improvement; a little bit
17 different from what we were focused on at the end
18 of this past year, specific to evidence-based
19 medicine and the data issues we were talking about
20 related to that, that area.

21 And so I thought it would be
22 helpful to start thinking about some other uses for
23 health information and suggest to you that we might
24 want to consider expanding our definition of health
25 information technology beyond just electronic

1 health records and health information exchange and
2 think a little more broadly about the need for
3 information for supporting the work that we're
4 doing and the health system in general.

5 And we'll suggest, at the end of
6 this session, or at least ask you if you would like
7 to change that part of our model and change that
8 one word from "health information technology" to
9 "health information infrastructure."

10 And so I'm just going to go
11 through a few graphics. These are just pictures
12 that might not be the best graphic description, but
13 following this conversation at our last meeting
14 about the need for community-based health
15 information and some of the issues that we run up
16 against with accessing that information.

17 I thought it would be helpful to
18 think, first, in terms of all of the different uses
19 of health information, and then what all of the
20 different components of a health information
21 infrastructure are.

22 And so I just posed some ideas.
23 We've been focused initially on clinicians' uses of
24 health information for making treatment and
25 diagnostic decisions and in partnership with the

1 patients. Also patients, individuals, families,
2 and consumers participating in decision making and
3 needing specific evidence-based health information
4 for those purposes, but also using that information
5 for making decisions about lifestyle, health care
6 purchasing decisions, personal health management.

7 Something we have touched on but
8 not gotten into too deeply yet are the uses of
9 health information by health care executives and
10 health care managers for performance management,
11 performance improvement, and for making their own
12 business decisions.

13 Uses by health care plan
14 administrators -- and I don't know that I'm
15 anywhere near close to the beginning of a bulleted
16 list of how health plan administrators might use
17 health information for making decisions about plan
18 design, for tracking and intervening in potential
19 areas where there might be fraud, waste, and abuse.
20 It's just a starting point that I came up with off
21 the top of my head.

22 We've talked about government
23 policy-makers make decisions, use health
24 information to make decisions for public health
25 program design, making reimbursement decisions

1 related to publicly funded health care plans, and
2 making regulatory decisions.

3 Another area that we've touched on
4 before -- again, Dr. McLaughlin will provide an
5 overview for us about how public health officials
6 use health information for conditions of public
7 health importance, for identifying those and
8 controlling them.

9 The area where community leaders
10 get involved in identifying initiatives to improve
11 health at the local level and the role that they
12 play and how they use or would hope to use health
13 information, both for making sure that they are
14 making data-based decisions about the direction for
15 their community, and then also able to evaluate in
16 following up.

17 So I was hoping that it would be
18 helpful for all of you to start putting some boxes
19 around, but also expanding our concept of how
20 health information is used, how it's needed -- we
21 actually started touching on this again this
22 morning in Mark's presentation -- and identifying
23 where there might be some data gaps that wasn't
24 allowing Mark to be able to answer some of the
25 questions you posed, the same sort of questions

1 that other administrators and managers and
2 government policy-makers might have. And so we
3 could be thinking about some of these other data
4 gaps and issues in future -- for future
5 decision-making purposes.

6 And thinking about these other
7 four different areas that might support the health
8 information infrastructure -- and we need to have
9 the data in the first place. And I just started a
10 list of different data sources that we have
11 available right now, both through clinical data
12 sources as well as population-based data systems,
13 like the Vital Statistics system, Behavioral Risk
14 Factor Surveillance System, the Youth Risk Behavior
15 Survey.

16 We have a number of disease and
17 condition registries, as well as the vaccine
18 registry. The state's public assistance system and
19 the information we've been able to gather through
20 the eligibility information system for that
21 program, as well as various clinical data sources,
22 including the Medicaid Management Information
23 System -- MMIS -- and the hospital discharge data
24 pages.

25 And I was actually talking with

1 Colonel Friedrichs on one of the breaks. And just
2 as an example, we started talking about this a
3 little bit in advance, in follow-up to the
4 conversation we had during Mark's presentation this
5 morning about -- just to give an example of how the
6 commission might, in the future, think about a
7 health information problem and how we might carry
8 that through to a recommendation.

9 Again, this is just an example.
10 I'm not suggesting this is a direction on this
11 specific issue the commission would want to go.

12 But I was talking with another
13 epidemiologist in the Department of Health & Social
14 Services yesterday. She was very frustrated
15 because leaders in the department had asked her to
16 answer a question about some aspect of health care
17 utilization and cost in our state's health care
18 system. And she was particularly frustrated
19 because she could get that information from the
20 state's hospital discharge database, the statewide
21 hospital discharge database. It's actually
22 administered by the State Public Health -- or
23 Hospital and Nursing Home Association, but the
24 department partners very closely with them.

25 She was frustrated because not all

1 hospitals participate in that data system, and so
2 she couldn't answer that question because she
3 didn't have complete enough data for the whole
4 state.

5 And we had debates probably going
6 back 20 years regarding whether a hospital
7 discharge database for the state is something that
8 should be mandated, that hospitals be required to
9 participate in, or whether it should be voluntary.

10 And up till now, it's voluntary,
11 but it has resulted in some significant gaps in
12 terms of population, being able to answer some of
13 the questions that health program leaders want to
14 be -- need to be able to answer.

15 So just as an example, if you all,
16 in identifying gaps and inability to answer some
17 questions as Mark identifies for us some of the
18 gaps in data that he's having trouble with
19 answering some of your questions about, we might
20 follow the path through this funnel and identify
21 what the issue is, if it's a gap in availability of
22 data or having a complete data set.

23 And then to Pat's earlier point
24 today, tracking back on what the root cause is of
25 the problem: Is the root cause that we don't have

1 a data system? Do we not have appropriate
2 technology in place? Is it just that we have data
3 gaps because everybody is not participating in
4 providing the data? Or is there some other policy
5 problem related to -- that's creating a barrier to
6 it? If we have a workforce issue -- we just don't
7 have capacity in the workforce to fund staff, or we
8 don't have appropriate types of staff in the
9 positions to be able to analyze the data.

10 I'm not going to go through any
11 more of these slides. I'm hoping you had a chance
12 to take a look at them. This is just, again, a
13 rough draft, beginning to put together a picture.

14 COL. FRIEDRICHS: Deb, before you
15 leave that last slide there --

16 MS. ERICKSON: This one?

17 COL. FRIEDRICHS: Pat -- no, I'm
18 sorry, the one you were on. Right there.

19 Pat, or some of the other folks
20 that have worked with ASHNHA, for the hospitals
21 that don't provide data --

22 MS. ERICKSON: We need you to come
23 up to the microphone.

24 COL. FRIEDRICHS: Sorry. This is
25 my after-lunch lolling, after sitting for so long.

1 For the hospitals that don't
2 provide data to the ASHNHA database, which then the
3 state uses -- I don't recall many of the
4 discussions, because I haven't been at the meetings
5 where this has come up -- why are they not
6 providing that data, or do you recall specific
7 reasons for that?

8 MR. BRANCO: I recall very
9 specifically, because my hospital is one of them.

10 MS. ERICKSON: Oh, that does not?

11 MR. BRANCO: That does not. And
12 part of the piece is feeding the data. As it stands
13 right now, it's a manual process on our end to input
14 the data. So what we've done is gone back to our
15 system infrastructure to produce -- it's a
16 \$60,000 repair. Pretty small change. But
17 significant for a small hospital -- to put a
18 structure in place to automatically mine the data to
19 input into the state system.

20 It's simply -- it was simply a
21 matter of resource availability, not a reluctance
22 to provide the data. And that's fairly uniform for
23 those who haven't supplied data yet.

24 MS. ERICKSON: That's just an
25 example of the direction our conversations can take

1 as we identify gaps. And if we have a good
2 understanding of what all of the components of a
3 full health information infrastructure involve, then
4 I think it will help facilitate the conversation in
5 getting back to those types of root causes and then
6 being able to make sure that we're identifying
7 recommendations that are going to actually make a
8 difference and get at the root problems, rather than
9 shooting in the wrong direction.

10 So really all I wanted to do today
11 was to put out the concept that we might consider
12 expanding our concept of that foundational piece of
13 the health care system beyond health information
14 technology and limiting that to electronic health
15 records and health information exchange, and think
16 more broadly about the health information
17 infrastructure and consider changing one word in
18 our pyramid graphic design of our strategy from
19 "health information technology" to "health
20 information infrastructure."

21 But you can ponder that for a
22 little while, and I think we'll have Dr. McLaughlin
23 goes first. As Dr. Hurlburt mentioned,
24 Dr. McLaughlin is our state epidemiologist, working
25 out of the Division of Public Health, and the chief

1 of the section of epidemiology in the Division of
2 Public Health and Health & Social Services. And
3 he's just going to share a little information with
4 you about public health uses of health information.

5 DR. McLAUGHLIN: Great. Thank you
6 very much, Deb. First of all, can you hear me okay?

7 MS. ERICKSON: We can hear you
8 well. Thank you.

9 DR. McLAUGHLIN: Excellent. Well,
10 hello, everyone. So Deb asked me to provide you all
11 with a basic outline of the public health uses of
12 health information, including how health information
13 is used to monitor health status and to diagnose,
14 investigate, and control disease.

15 And she also asked me to briefly
16 describe some of the sources of public health data
17 and the authority under which health departments
18 are allowed access to health data. So in order to
19 sort of paint this picture for you, I'll provide
20 you all with a brief overview of the structural
21 framework for public health practice, from an
22 epidemiologic perspective, and then I'll move into
23 more specifics about data uses in public health.
24 Then I'll finish up with presenting some examples
25 of how a health information exchange might be

1 useful for public health practitioners.

2 So, first, let's just start with
3 some definitions. "Public health" is defined as
4 "The practice of preventing disease, prolonging
5 life, and promoting health in populations through
6 the organized efforts and informed choices of
7 society."

8 And epidemiology is the basic
9 science of public health. "Epidemiology" is
10 defined as "The study of the distribution and
11 determinants of health-related states and events in
12 specified populations, and then the application of
13 this study to the control of health problems."

14 Epidemiology is used basically to
15 improve our understanding of health and disease and
16 thereby provide an evidence-based rationale for
17 implementing public health interventions. So the
18 practice of epidemiology sort of follows in orderly
19 sequence.

20 The first task of the
21 epidemiologist is to count cases or events through
22 surveillance efforts. We then make population
23 comparisons, we develop hypotheses, we test these
24 hypotheses, and then we make scientific inferences.
25 And based on those inferences, then, we have the

1 data to implement and the rationale to implement
2 public health interventions, such as removing
3 contaminated food from the food supply if there is
4 an outbreak, a food-borne disease outbreak, or
5 implementing handwashing campaigns, or procuring
6 and distributing vaccines, or using antibiotics
7 appropriately to prevent the spread of a
8 communicable disease.

9 Now, as I mentioned, performing
10 surveillance for public health problems is the
11 epidemiologist's first task. And "public health
12 surveillance" is defined as "The continuous,
13 systematic collection, analysis, and interpretation
14 of health-related data needed for the planning,
15 implementation, and evaluation of public health
16 practice."

17 So surveillance data are used for
18 a number of reasons in public health, including:
19 Providing an early warning system for impending
20 public health emergencies, and thereby sort of
21 trigger epidemiologic investigations that may be
22 necessary; documenting the impact of an
23 intervention, or tracking progress towards
24 specified goals; and also for monitoring and
25 evaluating the epidemiology of health problems,

1 which then facilitates priority setting and helps
2 to inform public health policies and strategies.

3 So public health surveillance
4 really embodies sorts of a systematic cycle of
5 public health actions, and there are four sort of
6 main categories in the cycle. The first is:
7 Collection of pertinent data in a regular,
8 frequent, and timely matter.

9 The second is: Orderly
10 consolidation, evaluation, and descriptive
11 interpretation of those data.

12 The third is: Prompt distribution
13 of the findings to stakeholders.

14 And then finally: Implementing
15 actions to control and prevent disease.

16 So public health surveillance
17 relies on several approaches to data collection.
18 There is active surveillance, where public health
19 agencies actually initiate surveillance by
20 contacting data sources -- for example, a health
21 care provider. So these data sources are the ones
22 that are most likely to have current information
23 related to an urgent situation.

24 For example, during an outbreak of
25 an infectious disease, we may call health care

1 providers. Let's say there is an outbreak in
2 Cordova. We may call the health care providers in
3 Cordova and say, "We've been informed of a possible
4 outbreak of such-and-such a disease. Have you all
5 seen any cases in the last several days?" That
6 would be an example of active surveillance.

7 And then there is passive
8 surveillance. And this is basically where
9 providers and laboratories report conditions that
10 are reportable by law to the health department.
11 And I'll talk about that in a little bit, but we've
12 got an established set of reportable conditions, as
13 I'm sure most of you already know.

14 There is also something called
15 sentinel surveillance, and this is an established
16 network of providers who agree to report cases of a
17 disease on a routine basis. And it's usually a
18 disease that's not already on the reportable
19 conditions list.

20 An example would be influenza-like
21 illness. We have a sentinel surveillance system
22 set up in Alaska for influenza-like illness
23 reporting, where we have a number of health care
24 providers who have basically volunteered every week
25 to report back to us the number of ILI patients --

1 influenza-like illness patients that they have seen
2 over the week. That's an example of sentinel
3 surveillance.

4 And then finally syndromic
5 surveillance. And this is the analysis of medical
6 data to detect or anticipate disease outbreaks.
7 And the term "syndromic surveillance" applies to
8 surveillance using health-related data that precede
9 diagnosis and signal a sufficient probability of a
10 case or an outbreak to warrant further public
11 health response.

12 An example would be diarrheal
13 illness, and you could use -- let's say there is a
14 sentinel surveillance system -- I'm sorry -- a
15 syndromic surveillance system that is set up at a
16 hospital emergency room, and we're looking for
17 diarrhea. And there is a big spike in diarrheal
18 illness that's coming through the ER door. If
19 there is a syndromic surveillance system that's
20 established, we might get a call saying, "Boy,
21 we're seeing a bit spike of diarrheal illness over
22 the last week. Is there anything going on here in
23 the community? Is there an outbreak or anything?"
24 And that can oftentimes trigger an investigation.

25 Okay. So now let's shift gears

1 and talk a little bit about the legal authority and
2 reportable conditions. So all states in the U.S.
3 possess constitutional authority under their police
4 powers to mandate reporting of a wide range of
5 infectious diseases, injuries, and other conditions
6 to public health agencies. Every state enacts
7 legislation that lists out the health conditions
8 that are reportable within their jurisdiction.

9 And states do vary somewhat in the
10 diseases that are reportable and the conditions
11 under which reports must be furnished, the time
12 frames for reporting, and the agencies responsible
13 for receiving the reports. For example, some
14 states have local health departments that actually
15 receive reports for their local jurisdictions. In
16 Alaska, the Alaska Division of Public Health
17 receives all of those reports.

18 So most states require reporting
19 by both health care providers and laboratories, and
20 that's true here in Alaska. And Alaska Statute
21 18.15.360 authorizes the Department of Health &
22 Social Services to collect, analyze, and maintain
23 public health databases and to access patient
24 medical reports that identify individuals or
25 characteristics of individuals with reportable

1 diseases or other conditions of public health
2 importance.

3 Alaska Statute 18.15.370 requires
4 the Department of Health & Social Services to
5 maintain a list of reportable conditions that must
6 be reported to the department by health care
7 providers and laboratories. And Alaska
8 Administrative Codes 7AAC 27.005 through .017
9 detail the diseases and conditions that are
10 reportable to the department.

11 So let's take a look at a few
12 surveillance data sources that are used in public
13 health, and I'll start out with vital statistics.
14 Information about vital events, like births and
15 deaths, have been collected, classified, and
16 published for centuries in Western Europe.
17 Collecting, linking, and tracking vital record data
18 provides a broad base of information important for
19 enabling trends to be examined over long periods
20 and wide geographic areas. So vital stats data --
21 that's the first one.

22 Now, the second data source that
23 I'll talk about is health reports. And these are
24 estimates of morbidity, particularly those for
25 infectious disease reporting. And they are based

1 on a national system of notifiable diseases that
2 has operated in the United States since 1920.

3 Reports from health care providers
4 and laboratories that are sent to health
5 departments make up most of the entries in these
6 databases. And this approach to surveillance has
7 really proved effective in characterizing seasonal
8 trends, showing temporal relationships to explain
9 trends, and detecting epidemics.

10 So the next data source I'll talk
11 about is hospital records. Hospital records
12 facilitate the acquisition of clinical data,
13 demographic information, sociological data,
14 economic data, and summary discharge data that's
15 used frequently by public health care practitioners
16 to perform epidemiologic investigations.

17 The next data source is disease
18 registries. These are population -- oftentimes
19 population-based registries that provide data about
20 all cases of specific diseases in a geographically
21 defined area that relate to a specific population.
22 And registry data can be used to calculate rates of
23 occurrence, to estimate survival rates, disease
24 progression rates, and disease-specific mortality
25 rates. An example of this would be the tumor

1 registry within the Division of Public Health.

2 And then the final data source
3 I'll talk about is health surveys, health surveys
4 such as the Behavioral Risk Factor Surveillance
5 system and the Youth Risk Behavior Survey system
6 provide valuable information about a variety of
7 public health issues. These surveys often involve
8 interviewing a representative subset of a
9 population on a recurring basis and provide
10 information on such things as the prevalence of
11 specifically risk factors, the prevalence of
12 disability, the incidence of disease, the
13 characteristics of health problems in a population,
14 and the kinds of care people have undergone.

15 So the final thing I'll chat with
16 you all about briefly -- and then I'll hand it over
17 to Deb and Paul -- is the potential public health
18 uses of a health information exchange for data
19 acquisition. And this is sort of just to get the
20 ball rolling, and I know Paul has a whole
21 presentation about this.

22 But some of the potential public
23 health uses of an HIE include:

24 No. 1, facilitating electronic
25 reporting of reportable conditions by health care

1 providers and laboratories.

2 No. 2, facilitating information
3 gathering during a public health investigation,
4 such as an outbreak investigation.

5 No. 3, utilizing laboratory data
6 to improve the understanding of nonreportable
7 disease patterns in the community in order the help
8 guide public health messages.

9 No. 4, utilizing laboratory data
10 to examine microbiology culture resistance patterns
11 to construct community-wide antibiograms that help
12 focus antibiotic selection based on local
13 resistance patterns.

14 And, finally, to facilitate the
15 monitoring of quality metrics on preventive care
16 for certain chronic diseases.

17 So, Deb, I think with that I'll
18 turn it back to you.

19 MS. ERICKSON: Okay. Thank you,
20 Joe.

21 And I just wanted to mention that
22 Andrea is on line to help answer any questions, if
23 you have any questions about any specific chronic
24 disease data uses or data systems, in addition to
25 updating us a little bit later on the community

1 health information system.

2 But does anybody have any
3 questions for Dr. McLaughlin?

4 Colonel Friedrichs?

5 COL. FRIEDRICHS: Thanks. This is
6 Paul Friedrichs. How would you characterize our
7 current system here in Alaska compared to other
8 states' ability to collect and share information
9 about their population?

10 DR. McLAUGHLIN: Well, I think --
11 thank you so much for that question. I think in
12 terms of reportable conditions, we are basically on
13 par with other states in the nation. I.e., we have
14 a very robust reportable conditions list, and we
15 have electronic laboratory reporting for -- I
16 believe now we're at five of our largest hospitals
17 in the state.

18 And I would say that most states
19 are right at about that same level. Most states do
20 not have electronic health care provider reporting
21 established yet, and we don't. And most states
22 have started electronic laboratory reporting. And
23 certainly we don't have all 20 -- whatever it is --
24 I guess 23 hospitals doing electronic laboratory
25 reporting at this point, but we've got our largest

1 hospitals on board with it.

2 And so I would say we are probably
3 right about in the middle of the pack on that.

4 Does that answer your question?

5 COL. FRIEDRICHS: Somewhat. Having
6 worked in states with a variety of resources
7 available, including some that have very robust
8 websites to which public health practitioners or
9 hospital CEOs can go to look at the data, I've not
10 found a similar resource here in Alaska to which we
11 can go to actually see our data in order to design
12 programs at either the hospital or the region or the
13 state level to identify potential partners.

14 Is that something that exists that
15 I just have missed? You mentioned data sharing as
16 being one of the four key components.

17 DR. McLAUGHLIN: Right. Right.

18 COL. FRIEDRICHS: Does that
19 capability exist now?

20 DR. McLAUGHLIN: Thank you for that
21 question, and I'm actually very excited to tell you
22 that we just made a huge step forward. At the end
23 of this presentation, if you have a little time to
24 take a look at the section of epidemiology's home
25 page under "Spotlights," the first thing you'll see

1 is a new link to what's called -- we're calling it
2 an interactive data resource for our partners for
3 STD data.

4 And what this provides is sexually
5 transmitted disease data -- specifically gonorrhea
6 and chlamydia -- by region for the state. And you
7 can -- it's actually interactive, so you can query
8 the system and see, over the last ten years, what
9 the trends have looked like in each region for
10 these two infectious diseases, which are our two
11 most commonly reported infectious diseases.

12 Now, in addition to that, we also
13 distribute epidemiology bulletins. I don't know if
14 you are on the epidemiology bulletin list, but we
15 distribute on average about two a month. And many
16 of these bulletins provide information about
17 reportable conditions. We have annual reports
18 about reportable conditions that go out through the
19 bulletins, as well as reports about outbreak
20 investigations that have occurred or other issues
21 of public health importance that need to get out to
22 our stakeholders.

23 So from the section of
24 epidemiology, those are our sort of -- the
25 epidemiology has historically been our primary

1 mechanism for getting information out to our
2 stakeholders. Now, with this Instant Atlas
3 technology, we're hoping to add additional
4 reportable conditions into the database so that
5 people can easily query that database.

6 And I know Andrea Fenaughty is on
7 the line as well, and Andrea can tell you about
8 some of the great work that is happening in chronic
9 disease along these lines in terms of Instant
10 Atlas, as well as she'll be talking to you all
11 about another technology that will be available to
12 everyone as well.

13 So, Andrea, I don't know if you
14 want to add to that.

15 DR. FENAUGHTY: Sure. Yeah. The
16 Instant Atlas is -- and I believe I shared that with
17 the group in one of my earlier presentations, just
18 in terms of some screen shots. But it's a way of,
19 really with any data that you have -- so we work a
20 lot, obviously, with the chronic disease, mortality,
21 and prevalence and risk factor data -- but
22 displaying it graphically.

23 So it's very easy to use; and
24 people can see region to region, however those
25 regions are defined, what the burden is, basically,

1 across the state. So we're very excited we're
2 moving forward with that as well.

3 MS. ERICKSON: Does that answer
4 your questions? Any other questions for
5 Dr. McLaughlin or Dr. Fenaughty?

6 Hearing none, I'm going to turn
7 the mike and the computer over to Paul Cartland --
8 again, our Health Information Technology
9 Coordinator for the state -- to update us on what's
10 going on with some of the major health technology
11 information initiatives.

12 MR. CARTLAND: Thanks, Deb.

13 I won't bore you with reading this
14 slide. These are the same definitions that I gave
15 to you I believe at the last meeting that I
16 presented at.

17 Out of the state Medicaid health
18 IT plan, we had to develop some health information
19 technology goals. We used, as the basis for those
20 goals, your previous reports. It seemed like the
21 thing to do. But we had meetings with the
22 commissioner and the deputy commissioners,
23 Dr. Hurlburt, and came up with these four primary
24 goals: improving access, reducing the medical
25 inflation rate, assure that health care services

1 meet high quality standards, and focus on
2 prevention -- not just clinical preventive
3 services, but the whole picture.

4 One of the things that we've done
5 or are doing, starting this month, is we've
6 developed a governance structure for health
7 information technology projects to ensure that all
8 of the HIT projects that we're doing are aligned
9 with those goals. So we'll have semiannual
10 meetings of the commissioner and the deputy
11 commissioners to update the goals. We'll have
12 monthly meetings of a governance committee across
13 the department to talk about how we can best
14 position all of the projects so that they are of
15 maximum use to all of the department, and then
16 monthly meetings of all of the active project
17 staffs to make sure that we're on track for meeting
18 those goals.

19 The health information exchange:
20 We contracted with the Alaska e-Health Network back
21 last year to manage the procurement and manage the
22 health information exchange. They went through an
23 exhaustive procurement process, which people from
24 all over the state participated in; and, at the
25 end, selected Orion Health to be the health

1 information exchange vendor.

2 That project is in a pilot status.
3 The contract was signed, I believe, in December or
4 January. There are several clinics and folks that
5 are signed up that are starting the process of
6 connecting to the health information exchange.

7 This slide here is kind of a
8 vision of where I think this is going, where the
9 state has a single connection to the health
10 information exchange that allows us to share
11 information with the health information exchange
12 and receive the data that we're all talking about
13 so that we can answer the questions to allow the
14 folks to make intelligent decisions.

15 The health information exchange
16 really needs a couple of things that don't
17 necessarily exist. One, you have to be able to
18 know whose information you're sharing and that it's
19 all information relative to a single individual --
20 you know, not me and my evil twin's information,
21 but just mine. So we have to know whose
22 information is whose. We call that a master client
23 or a master patient or a master person index -- you
24 know, pick something -- but it's really: How do we
25 know who this health information is about?

1 Then we also need to know who are
2 the providers. Who are the providers, one, so that
3 we know that whoever is sending this health
4 information is a reliable source of information,
5 and who are we sending it to, and are they
6 authorized to receive that information?

7 So we need a master client or a
8 master person index, and we need a master provider
9 index. One of the things that we're doing -- it's
10 not really in a slide here -- is we're working on,
11 with the Department of Administration, an identity
12 management solution, because this is really about
13 knowing who is who.

14 The master provider index -- it's
15 kind of important. It's not just -- I'm going to
16 pick on Dr. Laufer -- it's not just that I know
17 that I'm sending it to Dr. Laufer, but if I was a
18 doctor and I was sending a patient -- referring a
19 patient to him, but I know that he practices at
20 three locations, I kind of need to send the
21 information to wherever Dr. Laufer is going to see
22 the patient. I don't want to send it to someplace
23 he only goes once a month when he's going to see
24 him somewhere else or her somewhere else.

25 This is my somewhat crude attempt

1 at a high-level explanation on how it all has to
2 work. You have a health information request,
3 whether that's an electronic health record system
4 or at a doctor's office. It's an emergency room.
5 It's a personal health record that is available on
6 a secure website to the patient. There is a
7 request for information.

8 There is a whole number of things
9 that have to go on within the health information
10 exchange regarding security, making sure that the
11 data that is being sent isn't just broadcast in the
12 open, making sure that the fact that that
13 information is being transmitted is logged and that
14 there is auditing in place. There is consent
15 management: Is this information that the patient
16 has consented to have shared?

17 Authorization -- and the consent
18 and authorization are tied into that identity
19 management concept, making sure that we know whose
20 information is being shared, where it came from --
21 if it's Providence or whoever -- and who it's going
22 to, and are they on the consent list for that
23 information.

24 Once all of that has been
25 satisfied, then the health information exchange has

1 to go find that information. It has an index of
2 where all those pieces of information are, and it
3 goes out and grabs that information and then
4 presents it back to the requester who is authorized
5 to receive that.

6 So I hope that's not too
7 technical, but I tried to make it as high-level as
8 I could.

9 DR. LAUFER: The future will
10 probably include patients having access to it as
11 well; right?

12 MR. CARTLAND: Our intent is to
13 have a patient health record available. That's
14 really Phase II. You know, I'm guessing next year.
15 But one of the things that we're working on with
16 ETS, Enterprise Technology Services, in this
17 identity management thing is to create a way for
18 everybody to use their "myAlaska" user name and
19 password. Now, that's not perfect. We are working
20 out what are the issues and how do we fix them, but
21 so that everybody could go on and have access to
22 their health record.

23 DR. LAUFER: Can it really be
24 secure? I mean, the reason I ask is, my phone here,
25 which I'll get tired of and get an I7 or whatever it

1 is -- I can access all of our database from the
2 phone already. When I throw it away or dispose of
3 it somewhere, it's not a jump or a leap for a hacker
4 to now have access to all those charts. And that
5 information is valuable to someone, particularly
6 people who gamble on -- you know, or do risk
7 management.

8 I mean, there are so many
9 potential leaks that it's hard to imagine it could
10 really ever be secure, even with heavy, heavy
11 regulation. Maybe it doesn't have to be. I don't
12 know.

13 MR. CARTLAND: I'm not going to
14 pretend to tell you that it's perfectly secure.
15 Perfect security does not exist. But the Alaska
16 e-Health Network board and all of the working groups
17 are meeting and working through to do the best
18 possible job.

19 DR. LAUFER: I see it as the
20 future. I mean, it really is the answer, what you
21 guys are doing. Thanks.

22 MR. CARTLAND: Thank you.

23 One of the comments -- and I heard
24 a lady from the Rhode Island Quality Institute, who
25 talked about this a lot -- is we all assume that

1 that paper health record is secure, and that's no
2 more secure -- you know, the possibilities of
3 getting at it are a little more difficult, but at
4 the end of Hurricane Katrina when everybody's paper
5 health records are out on the lawn drying, that's
6 not secure, in my book.

7 DR. LAUFER: Well, if you can't
8 deny preexisting conditions, that's fine. Then it's
9 irrelevant.

10 MR. CARTLAND: So that was kind of
11 a snapshot of where we're at with the health
12 information exchange.

13 One of the other big things that's
14 going on is the electronic health record
15 incentives. We took a stab at guessing how many
16 providers and hospitals were eligible to receive
17 electronic health record incentives, eligible in
18 terms of they are of the right provider type,
19 et cetera, not do they have the right Medicaid
20 patient and counter volume to qualify.

21 We stood up our registration site
22 on January 3rd, one of the first 11 states. We
23 will make our first payment to a group of providers
24 probably next week. It just depends on how fast
25 they can key it into the state's payment system,

1 and we'll be off to the races.

2 But as you can see, although we've
3 been at this for essentially three months, we have
4 a whole 49 providers who have signed up out of
5 2,500.

6 CHAIRMAN HURLBURT: Is that
7 Medicaid only, or both Medicaid and --

8 MR. CARTLAND: This is just
9 Medicaid.

10 DR. LAUFER: I'd be interested in
11 the breakdown. Are they private? Are they
12 pediatricians, you know, who are all seeing tons of
13 Medicaid?

14 MR. CARTLAND: A lot of them --
15 well, the first 18, yes, are pediatricians.

16 DR. LAUFER: Okay.

17 MR. CARTLAND: The second nine are
18 pediatricians.

19 MR. LAUFER: Yeah.

20 MS. ERICKSON: What's the secret?

21 DR. LAUFER: Because the pediatric
22 population is fairly heavy Medicaid, because young
23 people today don't have much of a shot; and it's
24 real, real, real important to them. And it's fairly
25 well reimbursed, from the pediatric point of view as

1 well, when the funding comes through. But if it's
2 not paid, then it's -- yeah.

3 MR. CARTLAND: One of the barriers
4 that I'm seeing or that I'm hearing is that people
5 don't believe that the payments are actually going
6 to happen. And so hopefully, as we begin to make
7 payments, we'll see that change.

8 DR. LAUFER: They'll get on board.
9 Yeah.

10 MR. BRANCO: I am going to register
11 right now.

12 MR. CARTLAND: I can help you.
13 (Laughter.)

14 DR. LAUFER: But doesn't it
15 diminish in the future, even if the check is
16 written? Is that -- does this sunset?

17 MR. CARTLAND: No. For Medicaid --

18 DR. LAUFER: Yes.

19 MR. CARTLAND: -- you know, there
20 are two programs. There is the Medicaid and the
21 Medicare incentives.

22 MR. LAUFER: Yes.

23 MR. CARTLAND: The Medicaid
24 incentives pay better --

25 DR. LAUFER: Right.

1 MR. CARTLAND: -- but different
2 rules, you know, different programs. Not every
3 Medicare provider is eligible for Medicaid and vice
4 versa.

5 MR. LAUFER: You have to see a lot
6 of Medicaid -- a high percentage of Medicaid
7 patients to get it, I believe; is that correct?

8 MR. CARTLAND: Unless you are a
9 pediatrician, you have to have a 30 percent Medicaid
10 and counter volume for a 90-day period in the
11 preceding year.

12 DR. LAUFER: That's preselecting
13 for some very specific clinics.

14 MR. CARTLAND: Those are the rules
15 from the Reinvestment Recovery Act statute.

16 DR. LAUFER: I'm starting to get an
17 idea how the game works. Yes.

18 MR. CARTLAND: It's a federal law.

19 DR. LAUFER: Oh, yeah. Nothing
20 wrong with that.

21 MR. CARTLAND: But that's where we
22 are.

23 REPRESENTATIVE KELLER: Can I ask a
24 question?

25 MR. CARTLAND: Yes, sir.

1 REPRESENTATIVE KELLER: Are the 22
2 or whatever it is there, do they all -- I mean,
3 there is a master client index and a master provider
4 index all set up, then, for them and --

5 MR. CARTLAND: No, sir.

6 REPRESENTATIVE KELLER: Is that in
7 evolution?

8 MR. CARTLAND: The EHR incentives
9 for this year -- well, the first year for Medicaid,
10 okay, all the provider has to do is adopt,
11 implement, or upgrade to a certified electronic
12 health record, and the Office of the National
13 Coordinator for Health Information Technology has
14 set up a process for certifying electronic health
15 records.

16 One of the keys to having an
17 electronic health record be certified is that it
18 has the ability to share with a health information
19 exchange when one exists. Okay?

20 In the first year of meaningful
21 use -- and we'll talk about some of this
22 momentarily. You know, we can throw out the
23 slides, and I can talk about this -- but in the
24 first year, all that the provider has to attest to
25 is that they have the ability to share that

1 information, because the rule was written under the
2 assumption that health information exchanges
3 weren't going to be ubiquitous. Not everybody was
4 going to have access to one, and they didn't want
5 to limit people because the infrastructure was not
6 there yet for them to be able to share. So the
7 master client index and master provider index are
8 not required for this.

9 REPRESENTATIVE KELLER: And I would
10 presume that there would be no requirement as far as
11 the form. I mean, what one provider means when they
12 say they can share the information may be different
13 than what another -- is that pretty well defined? I
14 mean --

15 MR. CARTLAND: "Sharing" is defined
16 as "not sharing within your own practice." Sharing
17 has to be between organizations.

18 There are some Alaska regulations
19 that we're about to have adopted that help define
20 that. There is also a whole lot in the statute.

21 DR. LAUFER: Can I just say that
22 these incentives, even if you get all of them, are
23 not anywhere near the cost of a new EMR, the lost
24 productivity and the extra hours of time that you
25 typically spend at work.

1 So this is being done because
2 there is this belief that we're going to be able to
3 do a better job in general; or that you won't get
4 paid at all, which would be the other one. We've
5 spent about \$400,000 so far on an EMR, which is
6 imperfect and will need to be replaced at some
7 point.

8 MR. CARTLAND: The Medicare
9 incentive is \$48,000 over -- I'm not going to say,
10 because I don't remember over how many years. The
11 Medicare incentives -- if you don't adopt and begin
12 to share, your reimbursement ultimately goes down.

13 The Medicaid is not set up that
14 way. With the Medicaid, there is no penalty. And
15 the Medicaid -- the total payment is \$63,750, paid
16 over six years. The first payment, \$21,250 per
17 provider. Subsequent years -- and they don't have
18 to be consecutive years -- is \$8,500 apiece.
19 That's for providers.

20 Hospitals -- there is a whole
21 calculation based on discharge rates, et cetera.

22 REPRESENTATIVE KELLER: Could I ask
23 one more here? There's the chair. I didn't mean to
24 get into a dialogue here. I apologize.

25 CHAIRMAN HURLBURT: No, that's

1 fine.

2 REPRESENTATIVE KELLER: Actually,
3 it's more of a comment, but I'd like to get your
4 response. As I understand this, HIT was supposed to
5 save us a lot of money, and that seems like a pretty
6 -- it seems fairly far-fetched after this
7 discussion.

8 MR. CARTLAND: I don't believe that
9 I've ever claimed --

10 REPRESENTATIVE KELLER: No, I
11 didn't say you.

12 MR. CARTLAND: -- personally that
13 it will save us money. I think the opportunity is
14 not necessarily in savings but in cost avoidance.

15 You know, certainly there are
16 tests that are done more often than are necessary,
17 because one doctor doesn't have access to the data
18 from the test that the other doctor ordered at some
19 other facility. So there is a potential for
20 savings there.

21 Is that -- I can't quantify that.
22 And this is IT. There are costs involved. The
23 cost to implement an EHR far exceeds \$63,750. If
24 somebody is choosing to do it because they're going
25 to get the \$63,750, I'd say don't bother. You

1 know, do it because it's the right thing to do.

2 DR. LAUFER: It's all anecdotal,
3 but I think we are seeing cost savings, and we're
4 seeing better care. You know, I used to send
5 somebody to the ER with chest pain, and I would give
6 them a Xerox of their EKG and say, you know, "Make
7 sure that the ER doc gets this," and they'd still do
8 another one. But now you can see it there right
9 away.

10 And there are also subtleties,
11 like the -- a real painful patient for us is the
12 over-utilizer of narcotics, which is a huge problem
13 for our culture. And now -- not for Medicare and
14 Medicaid, but for the privately insured patients --
15 the program automatically runs and it leaps up,
16 "Oh, by the way, this guy got 60 from somebody else
17 across town." And we can call them on it right
18 away.

19 That's an invasion, I suppose, of
20 their privacy. We have an implied consent written
21 into the agreement to see us that we can do that.
22 And we usually dismiss people like that
23 immediately, because it's dishonest and I don't
24 want to be contributing to the death by overdose of
25 yet another young Alaskan. I love that. That's

1 worth a lot to us.

2 COL. FRIEDRICHS: And I would echo
3 your comments. We're to the point now in the DOD
4 system where our database encompasses every
5 prescription filled in any military facility or paid
6 for by the Department of Defense in any commercial
7 pharmacy. So when Mr. Friedrichs walks with that
8 now third prescription for OxyContin -- he's filled
9 one in Ketchikan, and he's filled one in Seattle,
10 you know, as he's flown up the coast or taken the
11 ferry. And then he shows up in your office. Our
12 system will actually say, "You know what?
13 Mr. Friedrichs has got a bigger problem."

14 So that is the beauty of it, when
15 you can begin to identify those folks. And we know
16 that one of the challenges of addiction is first
17 recognizing that you have an addiction. And so
18 this does become a very important patient safety
19 tool there.

20 But it's hugely expensive. In our
21 DOD system now, the cost -- if I remember
22 correctly -- is north of \$3 billion that we have
23 spent on our system. Now, is the overdose of one
24 Mr. Friedrichs worth \$3 billion? That's a moral
25 and an ethical discussion along the way that I

1 don't know that this commission needs to get into.

2 What I'm struggling with in the
3 whole overview of what's happening right now is:
4 So what? From the standpoint of the commission
5 here, we've listened to Dr. McLaughlin again. And
6 I want to publicly commend Dr. McLaughlin and his
7 team. I think their epidemiology updates or
8 bulletins that they put out are very good. I think
9 the way that they handled H1N1 was superb,
10 benchmark across the United States.

11 So what, from the standpoint of
12 this commission? Where are we supposed to be
13 helping the Legislature go, in helping the Governor
14 go in envisioning how to improve access, how to
15 control costs, and how to improve quality in the
16 context of this discussion?

17 I mean, a lot of what we have
18 heard so far is: Here's what we're doing right
19 now. I would ask, respectfully, the two on the
20 line and Paul, if you would, to help us with the
21 "so what" part. I know where the federal
22 government, at least on the DOD and the VA side, is
23 going. Where would you all ask us to envision
24 Alaska going in order to, number one, be specific
25 and measurable, as Senator Olson said; and then,

1 number two, to improve access and quality and
2 control costs?

3 MR. CARTLAND: It's going to be a
4 process. One of the things that we set out, we had
5 the first meaningful use strategy meeting on Tuesday
6 of this week to say, "We are expecting the providers
7 and the hospitals to share information
8 electronically and to share with us quality
9 measures. What are we going to do with them?"

10 Okay. The very first quality
11 measures that are going to be submitted are going
12 to be submitted on a website. And I'm not sure
13 that the information that is going to be submitted
14 initially is of any real value, other than to say,
15 "Yes, the provider is out using their electronic
16 health record."

17 One of the requirements is that
18 they report the percentage of patients over 13 that
19 they have recorded a smoking status on. Okay? So
20 there are three choices: Either they are a smoker,
21 they were a smoker, or they have never smoked. And
22 I'm going to find out that for X percent of their
23 population, they have reported an answer.

24 That's not real valuable
25 information from an epidemiology aspect. I don't

1 think they can make any real good use out of that.

2 But as we stand up the HIE and we
3 connect people to the HIE from their electronic
4 health records, then we can start to develop some
5 real information so that we can make intelligent
6 decisions.

7 You know, why am I here, talking
8 to you? I'm here because not everybody is
9 qualified to get an electronic health record
10 incentive. We need to find other triggers, other
11 incentives, inducements, enticements, other ways to
12 convince folk to adopt electronic health records,
13 because it doesn't do any good -- just like the
14 hospital issue that was discussed earlier: If you
15 don't have the whole population, how valid is your
16 data set?

17 MR. BRANCO: That's another key
18 point that I didn't bring up in my original answer,
19 too, and unidirectional data isn't very meaningful.
20 So the telemarketer who calls you at night and asks
21 you to participate in a survey. Are you really
22 wildly enthusiastic? Because it's really not going
23 to do anything for you. If they told you that,
24 "We're going to provide you with all the
25 information," and it's really critical to your

1 future, you may be more interested in participating.

2 The same with health care data.
3 That's why the exchanges, health information
4 exchanges are of more value. We can reap a benefit
5 by providing the information.

6 MR. CARTLAND: Right. But my point
7 is -- I think my point is -- that unless a provider
8 has adopted an electronic health record, the health
9 information exchange doesn't have anything to
10 exchange. So as you're formulating recommendations,
11 what are the things that we can do to help induce
12 people, induce providers to adopt electronic health
13 records and connect to the exchange?

14 DR. LAUFER: This is sort of
15 utopian, but I think that the EMRs are going to
16 evolve to the point that you won't be able to
17 practice without an EMR. You won't be competitive,
18 because the patients are going to demand access to
19 sort of a journal about their health and their life
20 and their narrative.

21 And this sounds crazy, but, you
22 know, Watson just won Jeopardy. I can be sort of a
23 computer-augmented clinician. I can be a bionic
24 doctor. And, you know, I see someone, and they
25 have Horner's syndrome, which I saw on Friday. I

1 know about that. I read about it in med school,
2 but I haven't seen anybody in 15 years with one,
3 and here he is.

4 So, right away, I want it to
5 trigger a series of thoughts, a differential
6 diagnosis, things I need to worry about
7 immediately. Thankfully, I had UpToDate, which is
8 web-based. And I thought, "Gee, you know, he has a
9 headache. What's that -- oh. Dissecting carotid
10 aneurysm -- that's fairly significant, and I want
11 to rule that out today." I won't be competitive if
12 I don't have access to that. It will be secondary
13 that we do it.

14 The parameters you measure I worry
15 about, because that data -- was the teen talked to,
16 if they were over 13, whether they smoke or not?
17 That wasn't the doctor. That was an intake person
18 who has been told, "Hey, make sure you document
19 this, because it's being measured."

20 And the classic thing about that
21 is patients lie all the time. "What does that have
22 to do with why I'm here? Of course I wear my seat
23 belt." They get really pissed. And, you know,
24 "Why is this person I don't even know asking me
25 whether I wear the seat belt?"

1 So you're going to get really bad
2 data. Sorry.

3 CHAIRMAN HURLBURT: We're coming
4 close to the end of our time on this session.
5 Go ahead.

6 MR. CARTLAND: Are there -- I tried
7 to list some of the things that I think are
8 barriers. Not all of the providers are eligible.
9 Not all the eligible providers can make the business
10 case. One of the year-one requirements is
11 e-prescribing. We rank 50th -- or is it 49th? I
12 don't remember -- in use of e-prescribing. And it's
13 not because the pharmacies can't support it. One of
14 the drawbacks is there is a fee.

15 DR. LAUFER: To whom?

16 MR. CARTLAND: There is a fee to
17 the pharmacy. Does that get passed -- where does
18 that get passed to? I'm not sure I know. But
19 SureScripts, Allscripts charge a fee to the pharmacy
20 for that service that they are providing.

21 Some states have enacted caps on
22 what that fee can be. Some states have built into
23 their insurance coverage for that piece, because
24 there is ultimately a cost savings in getting the
25 prescriptions right. But, you know, that's a

1 difficult business case.

2 One of the other barriers is the
3 meaningful use requirements itself. You know, "Why
4 am I even asking this question?" Or the meaningful
5 use requirements are going to increase over the
6 life of the program, so there is the uncertainty of
7 having to be able to meet those.

8 CHAIRMAN HURLBURT: Paul?

9 COL. FRIEDRICH: And again, I very
10 much appreciate the many barriers that are out
11 there. What would you recommend that we recommend
12 or consider recommending to the Governor and the
13 Legislature? Would it be helpful to improve access
14 and contain costs and improve quality to have all
15 hospitals report their discharge data to the state?

16 MR. CARTLAND: Absolutely.

17 COL. FRIEDRICH: Would it be
18 helpful for the state to have a portal that
19 interested users -- whether they be individuals,
20 public health entities, regional corporations, or
21 anyone else could view outcomes data, whatever it
22 may be that the state has collected?

23 MR. CARTLAND: I believe that would
24 be of great value.

25 COL. FRIEDRICH: Would it be

1 helpful for us to recommend that whatever fees may
2 be charged by a third party for e-prescribing be
3 absorbed by the state in order to save lives from
4 medication errors?

5 MR. CARTLAND: I don't know that I
6 can answer that question.

7 COL. FRIEDRICHS: Do you see where
8 I'm going with that question?

9 MR. CARTLAND: Yes. I would love
10 to give you the answer. And I don't know that I
11 have the information to -- we are -- we are data
12 poor. One of the things that I have to do, as part
13 of these health IT plans that I submit to the feds,
14 is I have to tell them, "Well, what percentage of
15 the providers have electronic health records?"
16 Okay. Could you define a "provider" for me? Who do
17 you include and who do you exclude from that count?

18 MR. BRANCO: So that's going to the
19 point of my question. To what extent are you
20 involving the providers throughout the state in your
21 discussions, developments, overcoming barriers so
22 that there are some practical elements that we can
23 begin to offer inside as well?

24 MR. CARTLAND: We're primarily
25 doing that through the Alaska e-Health Network

1 board, through the work groups that are set up that
2 I participate in. But that is our primary method at
3 this point. The health IT program is a staff of me
4 and two other people.

5 MR. BRANCO: You've laid the
6 foundation. Thank you.

7 MR. CARTLAND: Thank you very much.

8 DR. LAUFER: I think it's
9 important -- although it's in a primitive stage,
10 this is the right direction, from my point of view.

11 You know, we're still struggling
12 with, you know, the very, very basics of how to do
13 this stuff. And hopefully it isn't going to pan
14 out unless it leads to this kind of thing, or it
15 would just be wasted time and effort and money if
16 we don't have an exchange.

17 CHAIRMAN HURLBURT: Deb, do you
18 want to wrap up?

19 MS. ERICKSON: I think so.

20 Thank you, Paul.

21 (Applause.)

22 MS. ERICKSON: Very good. I think
23 we should go ahead and wrap up this session now; but
24 I would suggest -- first of all, I do want to ask
25 the question. I'm not going to flip back to my

1 presentation. Does it make sense to you to change
2 the one word in our -- the foundation of our
3 strategy related to health information, that we
4 expand it to the health information infrastructure
5 and not just focus on the word "technology"?

6 DR. LAUFER: Yes.

7 MS. DAVIDSON: Yes.

8 MS. ERICKSON: I'm seeing lots of
9 heads nod yes. Should we make a formal vote of
10 that, since that's our official strategy statement?

11 MR. BRANCO: So moved.

12 COL. FRIEDRICHS: Second.

13 MS. ERICKSON: I have a motion from
14 Mr. Branco, a second from Colonel Friedrichs. All
15 in favor?

16 Mr. Chair, if it's okay that I
17 take over that part of it.

18 I see all hands up. Any opposed?

19 Okay. We will officially change
20 that. I want to just make a note about this.
21 We're going to continue updating you on these
22 foundation pieces. The leadership is the updates
23 that we're getting from the commissioner when he's
24 here and the work that we're all doing, one of our
25 three foundation pieces. We'll have the Statewide

1 Workforce Coalition giving us an update on their
2 progress at one of our summer meetings. And I
3 wanted to update you on what's going on with health
4 information technology and begin thinking more
5 broadly about the other health data issues.

6 And as we -- one of the things --
7 just on a sidebar -- Colonel Friedrichs suggested
8 earlier -- and I'll talk with Mark later. He can
9 hear it for the first time now -- that will add to
10 his scope of work, that he maintain a list of the
11 data gaps he's identifying.

12 And perhaps, in follow-up to this
13 conversation, what we can do is Dr. Hurlburt and I
14 can go back to the department and work with our
15 data experts to see if we can have them identify
16 for us what they would say are the data gaps right
17 now and see if they can also identify other -- what
18 they would identify as the most significant
19 weaknesses in our health information infrastructure
20 in this state and bring that back to you at a
21 future meeting.

22 Does that make sense in terms of
23 follow-up to this conversation?

24 And I did want to point out to you
25 too -- I included in your notebooks, or at least

1 the additions to your notebooks that you received
2 this morning, the section from our 2009 report that
3 described where we were at then, and then our 2010
4 report updated information related to EHR, HIE, and
5 telemedicine. And included in there as well are
6 all of our current standing recommendations related
7 to those things.

8 So you might want to review those
9 recommendations that we made in 2009 specifically
10 to health information technology and see if any of
11 those are either outdated or insufficient at this
12 point.

13 Does that sound good for a wrap-up
14 to this session? Yes, Colonel Friedrichs?

15 COL. FRIEDRICHS: So I'd like to
16 ask how you would recommend, Mr. Chair, that we
17 specifically explore including those two
18 recommendations that we just discussed: One, that
19 the state develop a portal to display all of the
20 data which it has collected, which I believe goes
21 back to my esteemed colleague from Ketchikan's point
22 about bidirectional information sharing; and then
23 the second one that, by a time certain, we would
24 recommend that all hospitals participate in
25 contributing discharge data to the state repository?

1 How best would you envision us pursuing those for
2 our 2011 report?

3 CHAIRMAN HURLBURT: I take it your
4 second one -- go ahead, Deb.

5 MS. ERICKSON: Well, I was just
6 going to say, if it's okay if I can answer that for
7 our chair --

8 CHAIRMAN HURLBURT: Yes.

9 MS. ERICKSON: -- that I made a
10 note of those two concerns specifically and thought
11 as part of -- I would make sure that, in following
12 up with department staff initially, that I'm getting
13 their feedback on that and that we're reporting back
14 on those two issues specifically.

15 COL. FRIEDRICHS: Thank you.

16 CHAIRMAN HURLBURT: Yes. I think
17 taking the second one, we are reluctant, sometimes
18 too reluctant, probably, to put a Band-Aid on
19 people. So, for example, in assuring that all the
20 hospitals participate, I think we would want to
21 initially approach it in a collaborative way,
22 talking with ASHNSA folks about it; but the end
23 point being that, probably to get everybody to
24 participate, we will have to require that everybody
25 participates. But to try to get there in a

1 collaborative way.

2 COL. FRIEDRICHS: And please don't
3 misunderstand. I much prefer the carrot to the
4 stick, but if we are going to capture
5 recommendations, the sooner we capture them and
6 begin figuring that collaborative way out, the
7 better.

8 MS. ERICKSON: I think we are ready
9 for a break.

10 CHAIRMAN HURLBURT: Okay. Yes.
11 Let's.

12 MS. ERICKSON: Maybe we should
13 thank -- McLaughlin had to go off line for another
14 meeting, but if Dr. Fenaughty is still on line,
15 thank her for her participation today.

16 DR. FENAUGHTY: You're welcome.

17 CHAIRMAN HURLBURT: Thank you,
18 Andrea.

19 Okay. Let's take a 15-minute
20 break, so be back at about 25 of.

21 3:22 PM

22 (Off record.)

23 3:45 PM

24

25

1 UPDATE ON RELATED INITIATIVES
2 MEDICAID TASK FORCE
3

4 CHAIRMAN HURLBURT: All right. I
5 want to respond to Val's comments and question; but
6 I wanted to have her here because, at the end of it,
7 I want to turn it into a question to her. Because
8 something that she said kind of surprised me.

9 So let me maybe talk about the
10 Medicaid Task Force a little bit now.

11 MS. ERICKSON: Point out the fact
12 that folks have the report in their notebooks.

13 CHAIRMAN HURLBURT: Yes. Under
14 what tab?

15 MS. ERICKSON: 5.

16 CHAIRMAN HURLBURT: Under tab 5.
17 The Medicaid Task Force had their first meeting the
18 end of September, which was considered the October
19 meeting.

20 And the Medicaid Task Force was
21 requested by the Governor's office and initially
22 included four members of the administration: the
23 Commissioner, Bill Hogan at the time; the Deputy
24 Commissioner and Director of Medicaid, Bill Streur;
25 Allison Ellison, FMS, Assistant Commissioner for

1 the department; and me. And then there were four
2 members of the House and four members of the Senate
3 on that.

4 And the intent was to have six
5 bimonthly meetings to look at Medicaid, to look at
6 our level of expenditure, and to come up with some
7 recommendations to the administration regarding our
8 Medicaid program. And it was, of course, driven
9 by -- what are those three "C" things? Cost, cost,
10 cost, something like that.

11 DR. LAUFER: Access --

12 CHAIRMAN HURLBURT: Really
13 primarily driven by what was happening, where we see
14 the dramatic increase in costs each year.

15 And, Val, I was saying -- I'll
16 finish what I'm doing, but I wanted to come back to
17 what your comments were there at the end there and
18 your question, but I'll continue on with this right
19 now.

20 So that end-of-September meeting,
21 October meeting, and then there was not a meeting
22 in December November, December, or January. And I
23 think that probably related to the change in
24 commissioners and I'm not sure what else. There
25 were some delays in that.

1 It was also very difficult to get
2 the group together, I think because partly as we
3 approached the session, some of the folks in the
4 Legislature were saying, "This is the time to say
5 goodbye to my family again," or whatnot and to take
6 a little vacation. I think -- Wes, I think you
7 were there every meeting except the one. You
8 were --

9 REPRESENTATIVE KELLER: The one
10 where I was in Hawaii? Yeah.

11 CHAIRMAN HURLBURT: So then we met
12 again in early March; had a public meeting, time for
13 public comment last week; and then the final meeting
14 will be next week.

15 And so the staff work on the
16 report that you have in your book was done by a
17 number of folks in the department, primarily, and
18 put together. And as you see in the report that
19 you have, there are eight recommendations there;
20 and these will probably be largely finalized at the
21 meeting next week as recommendations to the
22 department.

23 The first, Option A, has to do
24 with patient-centered medical home. And this has
25 several options in here, but basically what this

1 is, is a recommendation to foster what's being
2 called the patient-centered medical home concept
3 and to look at options of pay for some of the
4 coordination that Noah already does, for example,
5 in his practice. But it's kind of the ideal of
6 what we all think is the way your relationship with
7 your primary care provider should be.

8 So there are some options on that,
9 but all of the options listed on there are for some
10 additional payment for that. There are no options
11 listed there for any risk sharing, up or down, on
12 that for any capitation-type arrangement, which
13 could be one of the things that comes out with the
14 Accountable Care Organization policies that -- I
15 saw something that said it was about to come out.
16 I thought it wasn't going to be till the end of
17 this month or next month, but should be out from
18 CMS fairly soon.

19 So it may be that some of these
20 recommendations are in the initial steps, getting
21 into that, but recognizing the value. There is no
22 quid pro quo put in any of those for a documented
23 reduction in costs or a flattening of the curve in
24 costs; although, just kind of anecdotally, I
25 worked in North Carolina for a while, and that was

1 really when it was -- the East Coast was pretty far
2 behind the West Coast as far as looking at care and
3 utilization and those kinds of things. And there
4 was an insurance broker back there who had kind of
5 developed a plan. And it was interesting that to
6 belong to that plan, you had to select a primary
7 care physician, period. That's all. You didn't
8 even have to go see him or her; you just had to
9 pick somebody. But just by doing that, he could
10 show that he lowered costs in the product that he
11 could sell.

12 So I'm not advocating that, but --
13 I think that I see these recommendations as being
14 an initial step, but clearly I think that that
15 would be a step forward. The Commissioner, Bill
16 Streur, is interested in doing that.

17 So that first section relates to
18 that, and then there are some examples where some
19 other states have used a similar model to that and
20 established some savings.

21 Now, this coincides with some of
22 the things that we have talked about here and I
23 think have alluded to earlier. We're thinking
24 maybe for the next meeting or the meeting after, we
25 want to look at the potential of having somebody

1 come from outside Alaska and talk with us. North
2 Carolina has done some interesting things there in
3 terms of implementing the patient-centered medical
4 home.

5 So that's a recommendation in here
6 and with some time frames listed on the
7 recommendation. And most of them are in a few
8 months, but that's looking at that.

9 The next one, Option B, is care
10 management. And that is on page 13 where it starts
11 there.

12 And this is just looking at taking
13 the portion of your patients -- that, again, Noah
14 has talked about -- that there will be a small
15 portion of your payment where it has been
16 recognized for many, many years that a small
17 portion of your payments do engender a very large
18 portion of your cost.

19 And I think that, in looking at
20 the Medicaid population here, there are larger
21 percentages as far as looking at them and having a
22 nurse manage those patients. And that, you really
23 can't do. Those numbers would be too big.

24 But you do need to look at some of
25 your folks who really have the highest morbidity

1 level, that are engendering the greatest cost.
2 And, there again, it has been pretty well
3 demonstrated by having mostly nurses -- depending
4 on the issues you're looking at, sometimes you'd
5 want to bring a social worker into the mix, get an
6 MSW, because they will have skills and abilities
7 and knowledge that a nurse won't generally have --
8 but largely with nurses, to look at that small
9 segment.

10 And probably that segment is going
11 to be some fraction of 1 percent, at least
12 initially to start. In my own personal experience
13 in that kind of a segment -- and this is for a
14 general Medicaid population, or it could be for a
15 commercial insurance population -- that your
16 savings, in that you improve quality, improve
17 patient satisfaction, you can do that very
18 collaboratively with physicians so that you're not
19 being seen as intruding on their practice but
20 really being an asset to them -- that your savings
21 are in the range of like 15 to 1. For every dollar
22 spent, you'll save \$15 as certified by financial
23 types, not just docs and nurses who don't know
24 things about dollars.

25 Yes, Keith?

1 MR. CAMPBELL: In going through
2 this, I see, in some of your recommendations under
3 care management, a call center with nurse staffing
4 and that sort of thing.

5 What has the state experienced
6 under their plan? I know there is a contractor --
7 that's one of the options, that people can call a
8 nurse center for information and things like that.

9 CHAIRMAN HURLBURT: I don't know
10 specifically. Generally, call centers have been
11 successful in facilitating appropriate care. And
12 that doesn't necessarily mean less care 100 percent
13 of the time. I think that if you are going to have
14 a call center, the call center and the nurses that
15 are there need to understand that there is the
16 expectation that they will be a factor in assuring
17 optimal care and using dollars appropriately, which
18 will usually mean saving money.

19 And I've seen call centers operate
20 where they -- that was the farthest thought from
21 their mind, and so it didn't save money and it
22 really didn't improve things.

23 But mostly call centers have, and
24 they can document pretty well some -- you know,
25 it's somewhat subjective judgment data -- but

1 pretty well have avoided inappropriate ER visits.

2 So Medicaid patients, particularly
3 in much of the country and certainly in Alaska, use
4 the ER inappropriately. Partly it's because
5 there's no copay. So if you have a cold, why not?
6 But also partly because there are other reasons.
7 Medicaid recipients often live in dangerous
8 neighborhoods, and the safest place to go is where
9 there is a hospital. You can get there. There are
10 a lot of lights. There's a lot of people around
11 there. And maybe you can't go to the Urgent Care
12 center or to your doc, because it's not physically
13 safe for you.

14 They also may be people who are
15 very lonely and don't have much of a social support
16 structure. And if you go to the ER, they are going
17 to treat you nicely.

18 Yes, Noah?

19 DR. LAUFER: And the minimum wage
20 employees who can't get off work to come see us when
21 we're open.

22 CHAIRMAN HURLBURT: Yeah.

23 DR. LAUFER: On Saturday -- we're
24 open Saturday, and, I mean, they flood in. And they
25 all say, "I'd like to follow up with you next

1 Saturday," but --

2 CHAIRMAN HURLBURT: Yes. So I
3 think that the nurse call center can. I don't know,
4 specifically.

5 I did have one personal experience
6 a long time ago here in Alaska, where we, in the
7 Indian Health Service at the time, and the state
8 collaborated and had a pilot for Medicaid enrollees
9 in Fairbanks and actually saw our ER utilization go
10 up. And we said, "Well, that's not what we
11 expected. We must be doing something wrong."

12 And we looked at it, and the
13 reality was it went up appropriately. When you
14 call a nurse, one of the things they should do is
15 if you say, "You know, I'm having chest pain," they
16 say, "Hang up. Call 911. Go to the ER."

17 And we found that in Fairbanks, it
18 wasn't the expected outcome, but it was the right
19 outcome, and it improved the quality because folks
20 were not going to the ER who should.

21 You know, that doesn't always
22 solve your money problems, but basically we're in
23 the business to do the right thing.

24 Yeah, Pat?

25 MR. BRANCO: A very similar story.

1 We've been using it for several years now to augment
2 our pediatricians on call, just a respite for a
3 nurse call program to take those initial calls.

4 Two pieces: Yes, the ER visits
5 went up slightly. It didn't save us dollars there,
6 but they were absolutely appropriate. The other
7 piece is the nurse call programs are rarely
8 indemnified for making medical judgments, so their
9 last sentence is always, "If you have any worry or
10 concern, by all means go to the ER."

11 CHAIRMAN HURLBURT: Again, my own
12 bias would be that a lot of these recommendations
13 are little baby steps, a little tentative compared
14 with what's happening in other places.

15 In the care management section
16 there, there is not so much about appropriate
17 utilization. For example, in MRIs -- and some of
18 you may have seen a recent study, how common it is.
19 And if you're a diagnostic imaging specialist or
20 company, and you've got somebody on the table and
21 you're getting an MRI, it costs you \$5, \$6, \$8 to
22 squirt some dye in, whether that was what was
23 ordered or what was needed. And the radiologist
24 generally very honestly will say, "Well, you know,
25 I've seen times when this helps, to get both

1 studies." And so then they tell their
2 technologists or their technicians "Just do it
3 every time." Well, it almost doubles your cost on
4 that.

5 And so where you are looking more
6 at what are the criteria or what's being offered,
7 it's a place where you can really control your
8 costs more, because sometimes you do want both with
9 and without. But there are other studies that you
10 want with, and other studies that you want without
11 dye.

12 We're not even looking at anything
13 like that here, but there is a potential I think
14 for significant cost saving. That's best operated
15 when you can have that operated by a group of
16 physicians who have some risk there and make those
17 kinds of evidence-based decisions. But short of
18 that, I think it's an appropriate role for payers
19 to play; but it should be done as collaboratively
20 as you can.

21 Ward Hanger is now with Radia,
22 which is a radiology group in the Puget Sound area.
23 They pretty much have scarfed up a good bit of the
24 radiology business there. They bought last year
25 Northwest Radiology Associates, which was the

1 biggest group in Spokane. And they really didn't
2 want to do business with the Medicaid program,
3 because the pay was lousy. Even though we would
4 pay them probably 20 or 40 percent more than what
5 the state would, it still wasn't very good.

6 But the group that they bought in
7 Spokane was the largest group there. It was a very
8 good group. They had multiple sites. They
9 practiced at Sacred Heart Hospital, the big
10 Providence Hospital, biggest employer in Eastern
11 Washington. Excellent hospital. But we just went
12 toe-to-toe with them on this and wouldn't pay them.
13 We had like a pediatric neurologist who was, you
14 know, a subspecialist who knew what they were
15 doing. They would order whatever the appropriate
16 test was, and they'd still say, "Nope. We want to
17 get them both."

18 And I would say to them, I said,
19 "You know, we're trying to do the right thing. We
20 don't want to just run roughshod. We think the
21 evidence supports what we're doing. Please show us
22 your evidence." And they never did. And then I
23 learned, after I left, they backed down and said,
24 "Yeah. I guess you're doing the right thing."

25 And we, you know, asked outside,

1 liked we'd ask orthopods, "Are we doing the right
2 thing in what we're requiring?" And we were.

3 We're not talking about doing
4 anything like that here. So, again, I think it's
5 an opportunity that we have looking forward, but it
6 is getting into some care management kinds of
7 things.

8 The third area there, and the next
9 several, actually, are related to pharmaceuticals.
10 This has to do with the generic medications and the
11 generics, especially generics where you have at
12 least two competing products. The generics are
13 much cheaper than the branded drugs. Sometimes the
14 generic is identical, and so that's one kind of
15 generic substitution where it's identical to the
16 brand drug and quite a bit cheaper. Sometimes
17 there is a therapeutic equivalency, it's called,
18 where it acts similarly.

19 Now, we have had a preferred drug
20 list here. It's kind of like a formulary that --
21 those of us who have been in the military obviously
22 know what formulary is. A preferred drug is a
23 little bit softer than that, but that's what states
24 have. But then how you enforce it varies.

25 And the way it has been enforced

1 here in Medicaid in Alaska is basically Noah could
2 write from a nonpreferred drug list and just say,
3 "This is what I needed to do" but didn't have to
4 get prior authorization on that.

5 And in the Medicaid population,
6 which is largely -- has been young women and
7 children, you should be able to have very high
8 rates of utilization of generic drugs, as I
9 mentioned earlier today. In the Medicare
10 population, your generic utilization rate can't be
11 quite as high, because there are some situations
12 where the branded drug is clearly going to be
13 better.

14 So we have had a preferred drug
15 list. We've had some kind of a prior authorization
16 process, but this is basically going to increase
17 that. They're looking at that.

18 Some of the things you'll see in
19 here I think are going to be tweaked, like to
20 prove -- there is like a requirement that you show
21 a failure on at least a couple of generic drugs
22 before you can go to a branded one. And I think
23 that that will be weakened, appropriately, on that.
24 One of the commenters said, "You mean somebody has
25 got to die twice before you can get the drug that

1 you want?"

2 So, you know, I think that was an
3 appropriate comment to make, not that you are going
4 to have somebody die, but I think that was a little
5 too tight there. But it is going to be -- to get
6 into some more requirements for use of generics.

7 Now, my own experience in that,
8 where we had about a 93 percent generic use, is --
9 and it has gone over time -- and physicians
10 understood and were very good about that, but we
11 did require prior authorization. But if the
12 physician called in, or the nurse called in from
13 the physician's office and talked with a pharmacy
14 tech in our office, we would roll over pretty
15 quickly on that, unless you just had somebody --
16 which was so rare -- that was an abuser. But if a
17 doc called in, and they said, "This is the reason
18 why we need to use that," we said, "Fine."

19 And, for example, with the statin
20 drugs, the cholesterol-lowering drugs, where now
21 you have -- and you have for several years now --
22 had both lovastatin and simvastatin, both Merck
23 products that were generic and are a lot cheaper
24 than Lipitor, the Pfizer product which is going off
25 patent this year -- that there were probably a

1 limited number of people -- and I would clinically
2 defer to Noah on this, I guess -- but a limited
3 number of people for whom Lipitor would be a better
4 drug.

5 But for most folks, like myself,
6 where I got some lousy genes, and I take
7 80 milligrams a day of simvastatin -- but it works
8 great.

9 Yeah, Larry?

10 DR. STINSON: I was wondering
11 specifically with pain medications, there's a couple
12 of considerations for generics, and I don't know if
13 anybody -- if this became part of the equation, and
14 maybe it should -- on the street value. Very often
15 people will come in and say they have to have a
16 brand name, because that's the only thing that
17 works.

18 Really, generics for narcotics are
19 very bioequivalent. And the reason why they want
20 the brand name is it's more valuable on the street.

21 Another thing to consider is very
22 often they'll say they don't want a generic because
23 it doesn't work, or they'll take a generic if it's
24 a tablet. Capsules, on the street, if you're going
25 to divert, have a lot less value, because you can't

1 cut capsules.

2 So specifically for pain
3 medications, these are a couple things, if I was on
4 that committee -- or something along those lines --
5 I would make it a point to really push the generics
6 for the opioid medications and to push capsules for
7 the generics, because it really cuts into -- it
8 de-incentivizes diversion quite a bit, and the
9 bioequivalency is quite good.

10 CHAIRMAN HURLBURT: And I don't --
11 that was not specifically mentioned. I think that's
12 a good idea.

13 There are some things in here.
14 One that's a total void in here in the pharmacy
15 area -- and I've talked with Chad Hope and Dave
16 Campana, our two pharmacists, about it -- is
17 there's nothing in here about specialty
18 pharmaceuticals. These are the high-cost drugs
19 that are like the ones that end in "MAB" or
20 something like that, or a lot of anti-cancer drugs,
21 the anti-rheumatoid type drugs. They are extremely
22 expensive.

23 In recent years, that has been --
24 the rate of increase in cost, the fastest growing
25 segment. It replaced diagnostic imaging as the

1 fastest growing segment. It's still relatively
2 small. It's still 1 to 2 percent of your health
3 care dollar, but increasing rapidly.

4 There generally have not been
5 generics available for those, partly because we've
6 not, as a society, come to grips with just what is
7 a generic for those kinds of drugs. But they can
8 be managed. There is nothing in here about that.
9 Other payers have been dealing with that for quite
10 a while. But that is not in there.

11 I think your suggestion is good.
12 And that's not in there either, and we'll pass that
13 on, Larry.

14 On the enhanced drug list, again,
15 it was making it a little tougher, to have to jump
16 through a hoop to use the nonpreferred drugs. Now,
17 that doesn't mean you have to do it every time, and
18 that these specifics aren't in here, but most
19 payers would say if you have somebody that needs
20 something that's off the preferred drug list, maybe
21 you need once a year or something to justify it.

22 Yeah?

23 DR. LAUFER: I want to ask a
24 question. This is me as me, not representing
25 primary care.

1 I've heard I think maybe in Oregon
2 they were trying to do this. They would put a
3 cap -- for primary care doctors, put a cap on the
4 milligrams of hydrocodone you could prescribe to a
5 patient per week. And if it's over that, it
6 wouldn't be covered. And if the patient feels they
7 require that -- because there is a lot of data that
8 going up and up and up on the doses doesn't help
9 them, yet we do it -- I could say, you know,
10 "You've reached your statutory limit. If you want
11 more, you're going to have to go see a pain
12 specialist."

13 DR. STINSON: Can I respond?

14 CHAIRMAN HURLBURT: Yeah.

15 DR. STINSON: That was a law that
16 passed in Washington state, and it has been -- it
17 has actually been well received. It was first very
18 iffy if it was going to get passed. The
19 pharmaceutical industry and some other lobbies were
20 not wanting to see it passed for a variety of
21 different reasons.

22 But once it had passed, it has
23 actually worked quite well. It has taken a lot of
24 pressure off the primary care physicians, who can
25 fall back on the mea culpa.

1 Noah is correct. These mega-large
2 doses, while there are some proponents of it,
3 almost in every study it has been shown to be not
4 helpful. What it really does is it causes a lot
5 more side effects more than the therapeutic effect.
6 And having the patients referred to a specialist
7 usually helps resolve the issue.

8 Plus at pain clinics, pain clinics
9 are required to do urinalysis testing and other --
10 have a program that is developed with the DEA, so
11 there is usually a little bit more screening. So
12 it gets to be -- for people at risk, it's probably
13 a better setup, and it's working out well.

14 The patients -- I just was at the
15 University of Washington on Tuesday, where I went
16 through a presentation on this. It's working out
17 well. Much less abuse, as documented by the ER and
18 other different agencies. Fewer deaths already
19 from overdose, which is not something to be -- is
20 more prevalent than what a lot of people probably
21 think it is. And cost savings.

22 CHAIRMAN HURLBURT: There are now,
23 I think it is, 17 states where the number of deaths
24 due to inappropriate use of legal controlled
25 substances is greater than from automobile

1 accidents, and it's a problem.

2 There is the concept, kind of like
3 Larry was talking about, of a morphine-equivalent
4 dosage, and we used to talk about that around
5 Washington state. Washington actually has, by
6 statute, the requirement now that for the Medicaid
7 enrollees, where there is a problem with substance
8 abuse, that you need to put them into a special
9 program, which I'll describe a little bit.

10 But this is going back probably
11 eight years ago, relating to the kind of story that
12 Paul just told. We started sending out letters
13 where we could see what we were paying for
14 pharmaceuticals to at least whoever was listed as
15 the primary care doc, and the individual who was in
16 the drug-seeking behavior was going to multiple
17 providers.

18 But we were a little hesitant,
19 because you're always thinking you don't want the
20 doc to think like you're intruding in their
21 practice, coming from the dark side from the
22 payers. But we'd say, "Do you know that your
23 patient is going to these other providers and
24 getting drugs from multiple pharmacies?"

25 And we were very gratified,

1 because we got a number of letters or calls that
2 said, "I didn't realize that. Thank you for
3 letting me know."

4 So that evolved. And Jeff
5 Thompson, who is the medical director with Medicaid
6 in Washington, kind of took the lead on it. But
7 they got it in statute, so if you have an abuser,
8 you lock them down. You require that they can only
9 get their controlled substance prescriptions from
10 one provider, usually a primary care provider.
11 They can only have them filled at one pharmacy.
12 And then you do look at the dosages that are there.
13 But it is a terrible problem with the diversion.

14 Yes, Paul?

15 COL. FRIEDRICHS: Thank you,
16 Mr. Chair.

17 These are some exciting programs,
18 and many of them mirror things that we've
19 implemented within the Department of Defense to
20 also try and bend our cost curve. One of the
21 things that we've struggled with and I would very
22 much appreciate your thoughts on -- if I remember
23 correctly, you said you're looking at a \$1.5
24 billion expenditure for medical --

25 CHAIRMAN HURLBURT: In fiscal 2012.

1 COL. FRIEDRICHS: In fiscal 2012.
2 And these, added up, total \$35 million in savings.
3 So are there other proposals -- you had mentioned
4 these were sort of the modest proposals along the
5 way. Who is looking at the more substantive changes
6 that would be needed to really bend that curve? Or
7 is that us?

8 CHAIRMAN HURLBURT: This is our
9 first step, so I think we have a lot of opportunity.

10 COL. FRIEDRICHS: And the reason I
11 bring that up -- and, Deb, I'm going to jump into
12 what you and I talked about a little bit on the
13 break there -- today we've heard some very
14 interesting discussions, and Val, I think, made the
15 point with one of them. You know, we talked about
16 why are we even talking about the definition of
17 health care, the so-what part of this.

18 I'll tell you that every meeting
19 that I go to begins with: Here's how much money we
20 will not have next year. And the end of the
21 meeting is: What have we done to close that hole?

22 At the federal level, the
23 discussion on a teleconference yesterday from one
24 of the very senior officials within the Department
25 of Defense was: People don't realize it. The

1 earthquake has happened, and we are waiting for the
2 tsunami to hit the DOD health care budget.

3 CHAIRMAN HURLBURT: And you know,
4 no matter how long you wear that uniform, you're
5 going to have that in every meeting you go to the
6 rest of your professional life.

7 (Laughter.)

8 COL. FRIEDRICHS: Well, I will tell
9 you, however much longer I do it, but that's a
10 change. I mean, for the 20-some-odd years I've been
11 doing it, we have not approached decisions or we've
12 not approached meetings from that standpoint. But I
13 agree that the federal government is broke, and
14 people are finally admitting that in public.

15 CHAIRMAN HURLBURT: But hopefully
16 it will be the Paul Friedrichs that can make the
17 decisions.

18 COL. FRIEDRICHS: No, no, no.
19 We're going to draft Noah. He's going to do that.

20 (Laughter.)

21 CHAIRMAN HURLBURT: He counts.
22 Right.

23 COL. FRIEDRICHS: But my point is,
24 as we go through these different discussions here
25 today, we've talked about a fair number of things.

1 In addition to drafting Noah, what else are we going
2 to do?

3 And I would ask my fellow
4 commission members here if we could agree that, in
5 the future, as we have a discussion about a
6 particular topic, that at the end of that
7 discussion we answer the so-what question before we
8 move on. Whatever the topic is, is there a
9 recommendation, an observation, we need more
10 information because this is important?

11 My concern is this commission did
12 a phenomenal job -- this particular group in six
13 months did a phenomenal job with very concrete
14 recommendations. We've met for that same six-month
15 period of time and came up our FY10 report. But
16 the rest of the trains are all rolling very rapidly
17 down the track, at least in my world, of making
18 hard decisions and recommendations about what needs
19 to change, and I think we have an opportunity to do
20 some of those same -- make those same
21 recommendations.

22 CHAIRMAN HURLBURT: Well, I think
23 generically that's appropriate. I think, for
24 example, in our session tomorrow morning on long
25 term care, there is going to be a decision point:

1 Is that an area that we feel we should be getting
2 into as the Health Care Commission? And then what
3 should be our next steps? What should be some
4 action points?

5 I think there are going to be some
6 things that we talk about, and I would say this is
7 more specifically a report to the commission. It's
8 informative. If there are suggestions -- like I
9 think Larry's suggestion was really valuable,
10 because I hadn't thought of that. And I've had
11 some other suggestions on that, but looking
12 specifically at the generics on the controlled
13 substances.

14 So it's not inappropriate to do,
15 but I think some things on the schedule will be
16 more of a report-type basis, just to inform us. So
17 I would say maybe not 100 percent of the time, but
18 I think that for generally what we look at, that's
19 absolutely right on. We should be action-oriented.

20 Yes, Dave?

21 MR. MORGAN: I will remember to get
22 the microphone.

23 I wanted to tell you that the ACO
24 regs came out this morning.

25 MS. ERICKSON: How long were they?

1 MR. MORGAN: 474 pages.

2 MS. ERICKSON: They were supposed
3 to be 1,000 by now.

4 MR. MORGAN: Well, the National
5 Committee on Quality Improvement has already gone
6 through this once, and basically they took those, en
7 masse, over. So it's not like we haven't seen these
8 before. I've already got six e-mails from Evey
9 (ph), Kierney (ph) and them saying, "We've read
10 them" -- that's the part I couldn't believe -- "and
11 we're ready to start on doing this."

12 I think, since we are supposed to
13 come up with an action item, I definitely think
14 that the patient home model should be coupled with
15 ACO's. And I would think, if we're going to bring
16 anyone up to talk about this stuff in that area, is
17 our friends at Blue Cross Michigan, who have done
18 significant savings through their Medicaid
19 contracts -- I thought that would make you happy --
20 and also their insurance of developing -- I mean,
21 literally Dr. Evey tells me many millions of
22 dollars, improved quality, and lowered the overall
23 cost.

24 But especially, to make sure if
25 we're going to have consumer choice and

1 competition, we have to have not just one form of
2 an ACO, but all four that are in the regulations,
3 so that -- from practitioners and multispecialists
4 and community health centers or primary care
5 centers -- set up and make sure that everybody can
6 compete and have different forms of this.
7 Competition sometimes does bring the best product
8 to the market, especially in the areas of the state
9 that we can.

10 I've attended all but one of the
11 Medicaid Task Force meetings that they have had.
12 Definitely this is just -- you kind of start on the
13 outside and kind of nibble your way in. And from
14 all the discussions, it looks like there is going
15 to be more major work; but the patient home model,
16 ACOs, and the things that we've been talking about
17 this afternoon are action items.

18 I kind of disagree with the four
19 years on patient home. I actually think we could
20 have some up and going much quicker. But we could
21 have more of them, and a more diverse market
22 structure, consumer choice, by having ACOs also
23 paralleling that development; so not just
24 integrated systems like tribal or hospital systems
25 can do it. If you have all four, AARP could put

1 together an ACO, if they are so inclined.

2 CHAIRMAN HURLBURT: Yes, I would
3 agree on the ACO. Let me just quickly run through
4 the other three, because I want to get back to Val's
5 comment and question.

6 Option F is how we procure drugs.
7 Currently, we have been buying at what is known as
8 AWP minus 5 -- average wholesale price. Average
9 wholesale price is a moving target. It can be set
10 at anything. We buy at average wholesale price
11 minus 5 percent. I think I have never worked
12 anywhere where we bought at any more than average
13 wholesale price minus 14. Generally you'll buy at
14 14, 15, 17, even 20 percent sometimes. So I think
15 we've been very nice buyers if we have been buying
16 at AWP minus 5.

17 But most of the world is moving
18 away, has moved away from average wholesale price,
19 and there are a number of other methodologies. The
20 maximum allowable cost methodology, which is a more
21 objective way to buy, we're looking at. So they're
22 looking at how we buy drugs, which should enable us
23 to buy more prudently.

24 Next is psychiatric medication
25 policy. This is looking at the exploding use of

1 drugs like atypical antipsychotic drugs. There was
2 concern expressed where, "Are you just going to
3 push people inappropriately back to tricyclics or
4 something?" No, that's not the intent.

5 Again, Washington state Medicaid
6 requires that if you have a kid less than six years
7 old and you're putting them on atypical
8 antipsychotics, that you get a second opinion. And
9 that was set up through Children's Hospital,
10 through a pediatric psychiatrist. And it costs
11 350 bucks to get the second opinion.

12 It turned out -- and it may have
13 been professional courtesy, but they seldom
14 overturn what a psychiatrist prescribed. Generally
15 nurse practitioners didn't get overturned much.
16 Fairly frequently, it was the family medicine docs
17 with little kids with the antipsychotics. So it
18 paid for itself.

19 It didn't save a lot of money but
20 definitely, I think, increased quality on what you
21 were doing. This is not that specific, but it's
22 moving into looking at the very widespread use of
23 the antipsychotic drugs.

24 The last one is Community First
25 Choice, and that, we'll talk about more tomorrow on

1 the community health aids; but that's there in your
2 packet.

3 Let me go back to Val's question
4 and comment. First a question: What are you doing
5 to be ready for 50,000 or 60,000 new Medicaid
6 enrollees? To be honest, that's a higher number
7 than I have in mind.

8 MS. ERICKSON: The 60,000 figure is
9 what's projected to be the total new insured,
10 currently uninsured. And approximately half of
11 those will be under Medicaid and approximately half
12 will be under the exchange, but because they are
13 receiving subsidies, not -- I mean, the exchange is
14 just a vehicle. So 60,000 total new insured
15 Alaskans is what's projected, half of those being
16 Medicaid.

17 CHAIRMAN HURLBURT: So I think the
18 number was high, but what are we doing to be ready
19 for it? As Paul just pointed out with his quick
20 math, this is nibbling at the edges, but it's a
21 start. It's going in the right direction. And if
22 we had, say, 50,000 or 60,000 new Medicaid
23 enrollees, and we went to Representative Keller here
24 or any of his 59 colleagues and said, "Well, our
25 billion and a half is not enough. We need another

1 \$750 million, of which \$250 million will be general
2 fund dollars," we would have to get the EMS system
3 out, because I don't think we are really prepared to
4 do that.

5 So I don't think we are, but
6 neither is anybody else. They have -- and I think
7 that's one of the things out in front of us. So I
8 think the answer has to be, no, we're not ready for
9 50,000 or 60,000 new enrollees to be paid under
10 tax-free dollars.

11 The other thing that I want to
12 turn around and ask you about, and that has to do
13 with about your comment about the tribal health
14 system, where it really is -- in off-road Alaska,
15 it is the health care system that we have.

16 And, you know, my own experience
17 was, when I started in Indian health, that the
18 legal bases of the program generally were treaties
19 between tribes and the federal government. The
20 mission, which was in place when I still came in
21 from the Eisenhower administration, was to
22 facilitate getting the health of Native American
23 people in the U.S., all races; and then getting out
24 of the business, under Kennedy, became the highest
25 possible level. Then in 1974, under President

1 Nixon, with the Indian Health Care Improvement Act,
2 it became a perpetual commitment by the federal
3 government to provide for the health care of Native
4 Americans in recognized tribes when they're living
5 in tribal areas.

6 When you look at the actual
7 treaties, I think that, as far as where we are in
8 Alaska, the wording, at least in my mind -- and Val
9 is a lawyer here -- but was the clearest that I've
10 seen, where it said "in the purchase treaty." So
11 it was not a treaty between the United States
12 government and any Native American groups in
13 Alaska, but with the purchase treaty with Russia,
14 that the United States would provide for the health
15 and education of the aboriginal peoples of Alaska,
16 period. Pretty terse but not limited, not ended in
17 time.

18 So your comment about what would
19 happen if the tribal health system went away was
20 kind of something that I don't see in the realm of
21 possibility because of the purchase treaty for
22 Alaska, because of the Indian Health Care
23 Improvement Act being accepted by the federal
24 government.

25 Now, I guess laws could change it,

1 but as a perpetual obligation -- because that would
2 be absolutely devastating to Alaska if we did not
3 have the tribal health system in rural Alaska.

4 So where were you coming from?

5 MS. DAVIDSON: So I guess my point
6 really was more global than particularly the tribal
7 health system. I mean, as we look at our health
8 care delivery system in Alaska -- and I mean
9 everywhere -- whether you are a family practice
10 physician in a small clinic, the tiniest clinic
11 anywhere in Alaska, or whether you are a major
12 hospital in a major health system, or something like
13 the Alaska Native Tribal Health Consortium, where we
14 do everything from sanitation facilities -- by the
15 way, that slide on the decrease of infectious
16 diseases was largely due to the improvement of
17 sanitation facilities.

18 My point was, if you look at the
19 health care delivery system of Alaska, somebody is
20 subsidizing someone else. That's the way that it
21 works. And to the -- what my point was, in many
22 parts of rural Alaska -- in fact, all of rural
23 Alaska -- the federal government and the tribal
24 health system really subsidizes the health care
25 delivery system that otherwise would be the state's

1 responsibility.

2 And I'm not going to go into all
3 of the laws and the federal constitution and all of
4 the various laws -- Snyder Act, Indian Health Care
5 Improvement Act, Self-Determination. I mean, I
6 could be here for days, and you would all be
7 sleeping so soundly; but I won't.

8 My point was, really, as we're
9 looking at shaping the future of the health care
10 delivery system, those shifts are going to happen
11 no matter what we do. And the reason that people
12 are all up in arms about health reform is because
13 that shift happened very suddenly. People didn't
14 feel like they had time to make the gradual
15 transition. The shift happened.

16 Why are -- many of the things that
17 people are uncomfortable about, why are they in the
18 Affordable Care Act? Because something wasn't
19 working, and so someone was successful in getting
20 that to happen.

21 So, for example, the high-risk
22 pools. Well, why do we need a high-risk pool?
23 Because people weren't covering them.

24 So my point really was, no matter
25 what it is that we're talking about -- and I'm not

1 speaking very eloquently nor briefly. I apologize
2 for that. But my point is, no matter what we do
3 and what recommendations we have here, we're all
4 shifting somewhere. And every change that we
5 recommend shifts the cost, shifts burden, and
6 shifts access in different directions; and we just
7 should be honest about the effects of those shifts
8 and be mindful of what are those opportunities.

9 And, quite frankly, one of the --
10 as long as we're talking -- I think Paul talked
11 about the opportunities for -- what are the other
12 big opportunities? And I should disclose that I do
13 work in the tribal health system, and I have for
14 the last 12 years, almost 13 years.

15 And in federal fiscal year 2009,
16 the state spent \$268 million in Medicaid revenues
17 on IHS beneficiaries who were not seen in the
18 tribal health system. If all of those folks had
19 been seen in the tribal health system, the state
20 would have saved \$134 million in the general fund.

21 Now, does it make -- so knowing
22 that, and knowing that the state could realize
23 50 percent savings to the state general fund for
24 Medicaid expenditures, does it make sense for the
25 state to look at enhancing the tribal health

1 system's capacity to provide care so that we can
2 get as many of those resources reimbursed by the
3 federal government to make that \$134 million
4 available to cover something else that is currently
5 an additional cost, where we're an additional cost?
6 Does it make sense?

7 And I guess the conversation I'm
8 trying to figure out here is, how do we get to
9 where we need to be? And at the same time,
10 recognizing that, in theory, that sounds great; but
11 we also have to ask and answer the question: Great
12 for who? And who does it shift that burden to?
13 Who does it shift the benefit to?

14 And ultimately, the one piece we
15 seem to not really be covering adequately is: What
16 about the person who is receiving that care? Where
17 are they in this mix? And I guess I just wanted to
18 interject a little bit of a -- late in the
19 afternoon. I think my third cup of tea is kicking
20 in -- a little bit of a reality check of: Okay.
21 How do we have that conversation that we keep
22 almost having, or we keep almost not having? And
23 I'm not sure how to get there.

24 COL. FRIEDRICHS: Amen.

25 CHAIRMAN HURLBURT: I would say

1 that the concept that we talk about, the
2 patient-centered medical home -- we don't get into
3 what that means, because it probably could mean
4 whatever you wanted it to mean. But basically, a
5 part of that concept is that the care decisions are
6 made in a collaborative basis between the provider
7 whose role is partly as an educator; but then having
8 the more educated patient, after they and the
9 provider have the conversation, make the care
10 decisions. That's, I think, inherent in the concept
11 of the patient-centered medical home.

12 Yeah, Noah?

13 DR. LAUFER: This is why defining
14 "health" is so important, and that's what you were
15 getting at. On the way down here, I rode down next
16 to a gentleman who was riding back from being seen
17 at Alaska Heart Institute by a cardiologist. He
18 flew there with his son to help him, and he was
19 going to have an ablative therapy. This is about
20 100,000 bucks in Anchorage.

21 And he sat down, and it was a --
22 he told me, man to man. He was a good man. We
23 talked about it an hour, and they decided not to do
24 it.

25 You know, how do you create that?

1 I can tell you for sure, if you take the power away
2 from the doctor, it would have happened. I mean,
3 that's the decision. He forewent income for a
4 hospital and income for himself, because it was the
5 right thing to do for the patient. The patient
6 accepted that because he was healthy.

7 CHAIRMAN HURLBURT: And it needs to
8 not be the interventional cardiologist that is the
9 doctor making that decision.

10 MR. LAUFER: Right. That's true.
11 I think that speaks highly of them. It also means
12 that they are paid well enough that he doesn't feel
13 that much pressure to do it. That's remarkable.

14 MS. ERICKSON: Larry has a comment.

15 CHAIRMAN HURLBURT: Yeah, Larry?

16 DR. STINSON: Valerie, I'll bet
17 that you have all kinds of data as to what
18 geographical area and how those Medicaid dollars
19 that could help the state, where they are being
20 spent and how they are being spent.

21 How do we fix that? How do we
22 help that? Does the state go in on a joint project
23 with tribal health? Do we build a community clinic
24 outside of ANMC in the Anchorage area? I don't
25 know.

1 MS. DAVIDSON: I think there have
2 been opportunities for collaboration that have been
3 explored in the past, and they have been very
4 successful. I know there was a demonstration
5 project in the Y-K region that I was personally
6 involved in that made a huge difference.

7 I think the challenge -- I mean,
8 in order for that to happen, though, a whole lot of
9 history has to be undone, a whole lot of -- I'm
10 choosing my words so carefully. Change is really
11 hard. It's hard for individuals. It's hard for
12 providers. It's hard for the payers. And getting
13 everybody to get in the room to have that
14 conversation is challenging at best. But getting
15 them to keep coming back to have that conversation
16 to the point of actual implementation is really a
17 challenge.

18 CHAIRMAN HURLBURT: Emily?

19 MS. ENNIS: If I could put a face
20 on two of those patients who might be eligible for
21 Alaska Native Tribal Health if it were available,
22 they would be an individual who is an adult with
23 developmental disabilities that has moved to an
24 urban center and is receiving services from my
25 agency, because those services aren't available in

1 the village or rural communities.

2 And another one might be a child
3 with complex medical conditions. Again, we, as an
4 agency, would very much like to see the child
5 receive services in their home community -- funding
6 source not an issue. We'd prefer them to stay in
7 the rural area with their family. But the services
8 are not there.

9 For quite a while, the Division of
10 Senior and Disability Services made, in conjunction
11 with the Department of Voc. Rehabilitation, some
12 major steps to try to bring these services back
13 home; but there were many barriers, and some of
14 those, as Val refers to, are maybe political. Some
15 of them are cost. Some of them are cultural. Some
16 of them are just sort of judgment calls.

17 But we serve about between 20 and
18 25 percent of individuals who would otherwise
19 receive Alaska Tribal Health, but the services are
20 not there for them.

21 CHAIRMAN HURLBURT: Larry?

22 DR. STINSON: You know, Valerie, I
23 grew up here, but I don't know the history of all
24 that in the climate. And with -- you know, we're
25 always talking about the pipeline is decreasing and

1 all of these things, and with shrinking revenues,
2 and with a possible savings of \$100 million plus --
3 you know, if I was in state government, I'd get in
4 the room with you. I'd get in the room with anybody
5 to talk about something like that. Now,
6 undoubtedly, there's obstacles, but maybe it's time
7 to give it another try.

8 CHAIRMAN HURLBURT: Yeah. In terms
9 of Medicare and Medicaid, Alaska Native
10 Medicare/Medicaid enrollees have the same rights
11 anybody else has. They can go to any provider they
12 want who will take them as a patient.

13 Now, when the tribal health system
14 pays contract health care, there is going to be
15 tension, and it gets back to Valerie's comment. We
16 forget the patient sometimes. If you live in
17 Ketchikan and you need to go to the hospital, when
18 I was in IHS -- or SEARHC is doing it now -- you
19 would rather have that patient go to Sitka, because
20 it then represents a variable cost to your system
21 because your fixed costs are already there.

22 Pat doesn't want to lose that
23 patient to Ketchikan, and the patient may say, "Why
24 should I have to go to Sitka? My family is all
25 here in Ketchikan, and they can come see me." So,

1 you know, nothing is easy. It's dynamic.

2 Yeah?

3 MS. DAVIDSON: But apply that same
4 argument to pharmaceuticals. The patient really
5 wants that high-end drug that he can sell on the
6 street. Does that necessarily make it right? And
7 so --

8 CHAIRMAN HURLBURT: No, no, no.

9 MS. DAVIDSON: -- I guess my point
10 is --

11 CHAIRMAN HURLBURT: I didn't say it
12 was. When I was in IHS, we tried to get everybody
13 we could in to Mt. Edgumbe instead of in the Sitka
14 Hospital, because our resources were limited.

15 MS. DAVIDSON: Yeah. I guess my
16 point is that whatever system you set up, you have
17 to be able to have an option for people to be able
18 to opt out or do something else if they had a -- you
19 know, if, for whatever reason, that doesn't work for
20 them, then you have a system that allows people to
21 be able to do something else.

22 And I think that's possible. But
23 it's sort of interesting that we're -- we sort of
24 pick and choose patient choice, depending on what
25 we're talking about. It's okay for

1 pharmaceuticals, but it's not okay with other
2 things.

3 And I realize that some of that is
4 federal law; but as long as we're dreaming big
5 about what our world should look like in terms of
6 the health care delivery system, those things all
7 do play a part, and they do impact each other.

8 So that's all. Thanks.

9 CHAIRMAN HURLBURT: We probably
10 better go on. I've gone over. I'm sorry. But Deb
11 told me she could do the rest in ten minutes, so
12 we'll see.

13
14 COMMISSION BUSINESS
15 FINANCIAL STATUS REPORT

16
17 MS. ERICKSON: Well, we could do
18 the rest, I think, in less than that, unless
19 somebody has real heartburn with our financial
20 reporting form. I'm going to go ahead and do that,
21 but then I'm going to go back to 15 or 20 minutes
22 ago, to finish the conversation that Paul was
23 starting and tied to some comments Dave made
24 immediately after that.

25 But for now, just to give our

1 minds a break from that last conversation -- which
2 was really important, but a lot -- to do something
3 real simple, a few administrative tasks.

4 Behind tab 6 is our second
5 trimester financial report. Does anybody have any
6 questions about that? I didn't really have
7 anything to highlight for you there.

8 COL. FRIEDRICH: I move that it be
9 accepted.

10 MS. ERICKSON: Paul moved that the
11 second trimester report be accepted.

12 MR. CAMPBELL: Second.

13 MS. ERICKSON: Keith seconded.

14 CHAIRMAN HURLBURT: Anybody
15 opposed? It's approved.

16 MS. ERICKSON: And it's approved.

17
18 COMMISSION BUSINESS

19 FINANCIAL DISCLOSURE FORM

20
21 MS. ERICKSON: Then on to the
22 financial disclosure statement. This is required in
23 our statute that all voting members complete the
24 financial disclosure. And I put the language
25 directly on the form from the -- from our law. I

1 also included the page that -- so you could see it
2 in context, if you wanted to, immediately behind
3 that, the page from our bill.

4 I worked with -- actually used, as
5 a starting point, APOC's form, which is way more
6 intrusive. And you can thank Dr. Hurlburt for
7 pointing out -- at one point, I had left the
8 amounts that you all would earn from these various
9 opportunities you might have in the health care
10 industry, and he pointed out we really probably
11 didn't even need that much, and our ethics attorney
12 agreed.

13 So this has been vetted by our
14 ethics attorney at this point. Judy Bockmon, if
15 you recall, came and gave you all a presentation on
16 ethics a couple meetings ago.

17 We have a little bit of
18 flexibility here. I have a couple folks who have
19 already filled them out and wanted to turn them in.
20 And I was actually thinking of this as a draft to
21 see if any of you had any questions yet. We have a
22 opportunity to tweak this before we finalize it.

23 One thing that I really wanted to
24 point out to all of you is that our statute
25 requires -- another place in our statute related to

1 our report requires that all of your financial
2 disclosure statements be included with our annual
3 report, so it will be included as -- it's in our
4 law. People keep telling me, "You know, just
5 because it's the law doesn't mean you have to
6 follow it." And I keep going -- just because it
7 says in the law we have to do a report by January,
8 we didn't have to. Nobody else does.

9 Jeff?

10 MR. DAVIS: Thanks, Deb.

11 I guess it's a question and a
12 comment. This first page -- well, on the last
13 page, it says this is a public document; right?
14 Something along those lines?

15 MS. ERICKSON: On the last page it
16 says, "This is a public document object." That is
17 correct.

18 MR. DAVIS: Which, I assume, means
19 is available at the request of the public; is that
20 correct? Or --

21 MS. ERICKSON: That would be
22 correct.

23 MR. DAVIS: Okay. So this first
24 page, then, has name, mailing address -- you know,
25 all this good stuff -- e-mail, phone numbers; all

1 financial data, that if I disclose someone else's --
2 any of those things, it's a HIPAA violation, yet
3 we're being asked to do that? I really am not
4 comfortable with my mailing address and my e-mail
5 and my contact phones being in a public document.

6 MS. ERICKSON: I think it's
7 assumed -- because way more detailed information is
8 required on the APOC forms. And I think the
9 assumption is -- with HIPAA, if the patient signs a
10 release, then -- not that it would necessarily be
11 made public, but presumably they could sign a
12 release saying their protected health information
13 could be made public.

14 CHAIRMAN HURLBURT: I don't see why
15 you can't use your work address.

16 MS. DAVIDSON: I'm using my work
17 address.

18 MS. ERICKSON: Use your work
19 address. That's the comment. Okay.

20 MR. DAVIS: That was not my
21 assumption.

22 MS. ERICKSON: Does that address
23 your issue?

24 DR. STINSON: Do you have another
25 one? I want to change my address. I already filled

1 mine out.

2 MS. ERICKSON: I will e-mail a
3 final, in case we make any changes to that.

4 Yes, David?

5 MR. MORGAN: That is what -- I've
6 filled out APOC reports, and that's what I did. I
7 put my -- I put where I worked and that type of
8 information. I didn't put my house, where I live,
9 which is permissible. But they are public
10 documents. We are a commission.

11 DR. LAUFER: Have you ever gone to
12 the website anchoragelive.com.?

13 MR. MORGAN: Yes.

14 DR. LAUFER: You can put anybody's
15 name in it, and it will show you on a map where they
16 live.

17 MR. MORGAN: Right.

18 DR. LAUFER: You can unlist
19 yourself, which I would recommend.

20 MS. ERICKSON: So it addresses your
21 concern if you know you can put your work
22 information, contact information down?

23 Yes?

24 DR. STINSON: Just e-mail me
25 another form, if you would, because I want to change

1 my address.

2 MS. ERICKSON: Yes, Wes?

3 REPRESENTATIVE KELLER: Can we use
4 your phone number?

5 MS. ERICKSON: As a contact phone?

6 REPRESENTATIVE KELLER: We probably
7 could, actually.

8 MS. ERICKSON: You could. People
9 call me for you, for you all. I get calls about you
10 and for you.

11 MR. DAVIS: And your e-mail
12 address?

13 REPRESENTATIVE KELLER: Use Ward's
14 for that.

15 (Laughter.)

16 MS. ERICKSON: Sure.

17 COL. FRIEDRICHS: See, she agrees
18 with using Ward's e-mail address.

19 MR. MORGAN: The scary part would
20 be --

21 MS. ERICKSON: No, use my address.

22 MR. MORGAN: No, no. The scary
23 part would be -- we all do this, and no one calls
24 us. No one sends us an e-mail. Nobody cares.

25 MS. ERICKSON: I think that's very

1 possible. I have been putting my direct line phone
2 number and e-mail address on the website and get a
3 lot -- I get a number of interesting phonecalls. I
4 do -- I mean, I was helping a woman in Fairbanks the
5 other day find -- she had behavioral health
6 problems. She's a single mother of a
7 three-year-old. She has diabetes. And she -- I
8 dropped everything. I was getting ready for the
9 meeting. I had to go home for dinner. It's like,
10 "We'll figure it out." So --

11 CHAIRMAN HURLBURT: And working for
12 the feds for a long time and having top-secret
13 security clearance and working for a number of
14 companies, the APOC form is far and away the most
15 intrusive I've ever completed in my life. And this
16 is nothing like the APOC form.

17 COL. FRIEDRICHS: It's been a long
18 time since you worked for the feds, because this is
19 my computer paperwork right here, which I'm in the
20 process of filling out.

21 MS. ERICKSON: That's what it is
22 now?

23 CHAIRMAN HURLBURT: But this is not
24 the APOC form.

25 COL. FRIEDRICHS: If the APOC form

1 is bigger than this, I'll yield my point.

2 MS. ERICKSON: Okay. Any final
3 questions or comments about this form? I will
4 e-mail the form out to you electronically, and you
5 can fill it in and return it to me.

6
7 COMMISSION BUSINESS
8 CONTRACTUAL PROJECTS STATUS REPORT
9

10 MS. ERICKSON: And finally, I was
11 just going to give you a real quick verbal update on
12 our contractual projects. We have two RSAs with
13 Mark right now -- with ISER, but for Mark's work.
14 And both of those expire the end of this current
15 fiscal year. I expect we'll actually have both
16 reports prior to the end of the fiscal year, at
17 least in some form that we can continue discussing.
18 He was nodding his head all along until I said that.

19 But we're shooting for having
20 the -- I think we just have some final narrative
21 writing going into the Affordable Care Act
22 analysis. And then the big cost study, we're
23 hoping to get that in May so we can be part of the
24 discussion again at our June meeting, and everybody
25 will have the handouts at that point. So he's

1 continuing to nod to that.

2 So the final contract that we're
3 working on getting in place today was with a health
4 care actuarial firm to conduct an analysis of
5 pricing and reimbursement in the state. We did go
6 through one solicitation process for that and found
7 the response that we received to be nonresponsive,
8 the proposal we received to be nonresponsive to the
9 RFP.

10 And I had conversations with
11 health care actuarial firms down south following
12 that, asking why they found our RFP to be too
13 restrictive; and a couple of issues were raised.
14 One -- and I never could have known this. I was
15 frustrated with our public procurement process,
16 because I asked for a preproposal conference and
17 would have found this out in a preproposal
18 conference, but it was against policy. We don't --
19 we only do it for big construction and IT projects.
20 Sorry. I had to vent for a second.

21 The large firms who work with
22 Medicare Advantage plans -- the federal deadline
23 for filing, annual filings for those plans, was the
24 day after -- I can't remember the exact date, but
25 it was the day following what I had put down as the

1 day for the final big deliverable for us, and it
2 kind of blew that out of the water.

3 And then the other thing I
4 found -- and this may be too much information --
5 but the state sued a health care actuarial firm
6 that was their employee beneficiary consultant
7 about three years ago, and apparently health care
8 actuaries can be a little risk-averse and expressed
9 some concerns about contracting to provide any sort
10 of analysis for the State of Alaska.

11 MR. MORGAN: How much did we hit
12 them for, \$100 million?

13 MS. ERICKSON: In was a lot of
14 money.

15 CHAIRMAN HURLBURT: It was a
16 \$5 billion error --

17 MS. ERICKSON: For a \$5 billion
18 error.

19 CHAIRMAN HURLBURT: -- on their
20 part.

21 MS. ERICKSON: So, anyway, I've
22 re-released the RFP, and we'll be working on seeing
23 what we can come up with for some approvable
24 liability limitation language for that, if possible.
25 So we're still on track -- a little bit behind

1 schedule, but we're still on tract with that.

2 And I wanted to mention -- related
3 to this, too -- that we have been hearing concerns
4 from the provider community about this study,
5 exactly what we're asking these questions for, what
6 we're going to do with the information; concerns
7 that, regardless of what our best intentions might
8 be as the commission, that findings from the study
9 might be misused by other policy-makers and others.

10 And in response to that, so far
11 I've talked with the executive directors of two of
12 the physician associations in Anchorage and for the
13 state -- Alaska Physicians and Surgeons and the
14 Alaska State Medical Association, Mike and Jim
15 both -- and offered that Dr. Hurlburt would come
16 and meet with them; and they were very grateful,
17 actually, for that, that contact and that outreach.
18 And Dr. Hurlburt will in fact be going to the APS
19 board meeting this next month and meeting with them
20 to talk about the study.

21 And the State Medical Association
22 actually asked if Dr. Hurlburt would come be their
23 luncheon speaker at their annual meeting in May,
24 and so that -- it's that first Saturday in May, I
25 think May 7th. And so he's on. I said, "As long

1 as you aren't serving rotten tomatoes, then you can
2 do that."

3 So we're hearing that and
4 attempting to address those concerns. So if any of
5 you are hearing anything more, have any other
6 suggestions for what we might do, and also maybe be
7 thinking about -- because one of the other thoughts
8 that we've had is that perhaps we could have a
9 conversation, outside a public meeting, after we
10 receive the initial report but before presenting in
11 a public forum before the commission the findings
12 from these results; if we could have a meeting with
13 the provider community to talk with them about how
14 the information will be shared to answer any
15 questions or concerns they have at that point.

16 Go ahead, Noah.

17 DR. LAUFER: Do we need to do a
18 report? I mean, I was struck by the article that
19 Futurist Flower wrote. And he said, you know,
20 "Where is the problem? Everywhere."

21 And I have a feeling that's what
22 it's going to show, is that it's everywhere. And
23 time will have gone by, and we're closer to the
24 cliff, and we spent money and don't have any
25 recommendations.

1 To me, the devil is in the detail.
2 Mark is trying, you know, to look at the detail,
3 and it gets ever more confusing. I don't know. I
4 would love to have one if we had it already. We
5 could -- Blue Cross has information that
6 theoretically we could look at. You know, I don't
7 know. It just seems like -- is this really going
8 to go towards a positive end, or is it --

9 MS. ERICKSON: Well, it's something
10 that we've been talking about doing for a long time.

11 DR. LAUFER: Two meetings now.
12 Yeah.

13 MS. ERICKSON: And, well, even
14 before that, but we didn't have money before.

15 And part of the concern has been
16 that there is a lot of anecdotal discussion about
17 what's going on with pricing and reimbursement --

18 DR. LAUFER: Yes.

19 MS. ERICKSON: -- but we don't have
20 any data about that. And so we're making -- we
21 don't want to make any decisions based on
22 assumptions and based on anecdotal information.

23 DR. LAUFER: The data has to be
24 good data.

25 MS. ERICKSON: Correct.

1 MR. DAVIS: I agree. It has to be
2 good data, which is why I think the approach of -- I
3 mean, you could look at our data, but then you have
4 -- "Well, that's just Blue Cross's data," you know.

5 So you have to have, I think,
6 multi-source; and it has to be done by a public
7 body like this, hiring a third party who is
8 qualified to do it, because this is tricky stuff.

9 And I think that was well said.
10 Deb. There is all this anecdotal stuff, but we
11 really don't know. And I don't think the problem
12 is everywhere. From my experience, I don't think
13 there is a problem with primary care. That's not
14 where there is a problem.

15 So I think it's important for us
16 to know where there's smoke and where there's fire
17 if we're going to do anything concrete and discrete
18 and make actionable recommendations.

19 MS. ERICKSON: Paul?

20 COL. FRIEDRICHS: I would echo and
21 highlight also, as I shared at previous meetings,
22 that both the Department of Defense and the
23 Department of Veterans Affairs are doing a similar
24 analysis already. And so decisions are going to be
25 made in the relatively near term -- I can guarantee

1 that -- about payments in Alaska, because there is
2 so much scrutiny in the federal government about how
3 disproportionate the costs are here relative to the
4 population.

5 And, you know, I will tell you, as
6 recently as this morning, having that discussion of
7 "Tell me again why I would station active duty
8 military in Alaska when it costs me a multiple of
9 1.7 to care for them versus stationing them
10 somewhere else?"

11 DR. LAUFER: There you go.

12 COL. FRIEDRICHS: And these are
13 real discussions that are happening as money gets
14 tighter. And I would agree with your observations;
15 certainly we've seen that also in our payer mix,
16 that we are not spending a whole lot of money on
17 primary care. We provide a lot of that within our
18 system. But even what we do have to contract for,
19 that's not where the huge disproportionate payment
20 is coming from.

21 So I would ask that we do press
22 forward with this and have the data to answer the
23 questions that are being asked today.

24 MS. ERICKSON: Just a follow-up
25 comment too. I just wanted to mention that I did --

1 it was very helpful that you mentioned that the VA
2 was doing that study. I was able to work with folks
3 here in the state and the VA contractors in Colorado
4 and a health care actuarial firm in Seattle to
5 follow up on that. I was able to get copies of the
6 contract and the solicitation. That was very
7 helpful.

8 COL. FRIEDRICHS: Thanks.

9 MS. ERICKSON: And I would look
10 forward to seeing the report, if and when it's made
11 public. I don't know how military and VA reports --
12 if they would be considered public or not.

13 DR. LAUFER: For a study of this
14 magnitude, what sort of depth do we get out of it,
15 or insight do we get? I mean, I feel that -- like
16 I've said, this is not a system; it's an ecosystem.
17 It's very complex with many niches.

18 And I had a discussion last night
19 with my -- the night before with my brother-in-law,
20 who works -- is a commission corps officer. He's
21 paid less than I am, and he's very efficient, but
22 he works in a \$200 million facility. He has
23 retirement for he and my sister, who is younger
24 than he is, in perpetuity for 75 percent of her
25 income. His health care is covered. He's not

1 exposed to the same liability.

2 You know, I cost more per hour,
3 but I'm just paying off my loans. I have no
4 retirement. I pay my own health care. I pay a 33
5 percent premium to all my employees because of the
6 outrageous cost of health care and their benefits.
7 I pay my own rent, and I take a huge amount of
8 liability. I own my own business, which could go
9 underwater quite quickly.

10 And there isn't real parity there.
11 It's sort of like -- well, a better example: I saw
12 a patient I grew up with. He's a plumber. He's
13 going to retire shortly. And he was doing this,
14 you know -- "Oh, Doctor. You're so -- you must be
15 smart," or whatever. And I'm thinking, "God, he's
16 going to retire with union benefits, health care
17 way before I could even conceive of it, and I'm
18 doing prostate exams all day. I mean, who is
19 smarter, really?" And he loved that. He thought
20 that was hilarious.

21 But, you know, if I look at -- I
22 could say, "Oh, well. Gee, this guy is making so
23 much" or "making so little" or "there is this
24 disproportionate cost," and I think that's
25 losing -- you know, we're bickering in the car

1 while we head off the cliff, and that's a waste of
2 time.

3 MS. ERICKSON: And one of the
4 things that we've seen in the RFP is for insights
5 from the actuarial firm into cost drivers as well.
6 And I'm trying to remember if we left cost shifting
7 in there. But I think this is a conversation we can
8 engage Mark in helping us frame and direct and
9 understand what some of the underlying costs might
10 be that are supporting variations in pricing and
11 reimbursement and ability to support practices.

12 DR. LAUFER: And then one last
13 thing. You know, I suspect -- I know that doctors
14 are paid more in Alaska than elsewhere, but we have
15 to pay more to recruit, even to primary care. There
16 probably are fires, because I can smell smoke also.
17 But, you know, these are our colleagues.

18 We're going to have this, and, at
19 the same time, say there is a manpower issue. And
20 that, you know -- you know that the free market
21 people are going to say, "Well, that's why we are
22 paid more." So we're going to hear that.

23 Anyway, I am just very nervous
24 about what a report says because, you know, we live
25 in the age of Enron accounting and, you know, AIG

1 was quite successful with a lot of accountants and
2 looking good until it blew up. Anyway, sorry.

3 MS. ERICKSON: Any -- Emily?

4 MS. ENNIS: Another question. I
5 was asked if there will be another appointment to
6 replace Wayne Stevens.

7 MS. ERICKSON: Oh, yes. Yes.
8 Thank you. I wonder if the same comment that Noah
9 made prompted the thought in your mind. I wanted to
10 update you all on our vacancy. I was thinking,
11 Noah, you actually could wear two hats for us.

12 DR. LAUFER: I don't think that's a
13 good idea. No.

14 MS. ERICKSON: So just an update.
15 Wayne's position seat on the commission was as
16 representing the statewide Chamber of Commerce and
17 representing the business sector, for a reminder for
18 folks that might not remember that, because he left
19 not long after we got restarted.

20 So they just refilled his former
21 position a month or two ago. Rachel Petro is the
22 new executive director of the Alaska State Chamber
23 of Commerce, and I've been talking with her. She
24 shared with her board that they needed to come up
25 with some nominees for the Governor to consider for

1 this seat, but they haven't quite gotten there yet.
2 I think they are really busy with the legislative
3 session. But I'm hoping we can get that seat
4 filled relatively soon, in time for our next
5 meeting.

6 So thanks for asking, reminding me
7 to fill you in on that point.

8 MS. ENNIS: You're welcome.

9 MS. ERICKSON: I'm wondering -- I
10 know we wanted to have this conversation when we
11 were fresh, so I don't know if you guys are up for
12 talking about process, to follow up on Colonel
13 Friedrichs's question earlier, because I am not
14 forgetting that.

15 Shall we talk about process a
16 little bit without me going back to the slides? I
17 was going to pull up a couple of slides to
18 facilitate this. Maybe we can just get a start
19 today, and then we can sleep on it and we'll talk
20 about it at the end of our meeting tomorrow?
21 Hopefully we'll have at least a good half hour at
22 the end of our meeting to talk about next steps.

23 I don't know if you can picture
24 the graphic or not, what we had laid out as an
25 outline of our process, how we were proceeding

1 through this process. The first step was
2 identifying the vision of our future system, and
3 one of the questions I'd written down is if we need
4 to do a little more detailed visioning or not. But
5 at this point, we're calling what we have for a
6 vision and our goals for this process good, based
7 on your decision at the earlier meeting, last fall.

8 REPRESENTATIVE KELLER: Deb?

9 MS. ERICKSON: Yes?

10 REPRESENTATIVE KELLER: Just I got
11 to leave. I'm not going away mad.

12 MS. ERICKSON: Don't leave mad;
13 just leave.

14 (Laughter.)

15 REPRESENTATIVE KELLER: When I come
16 up to the floor, I'll introduce you.

17 MS. ERICKSON: Good luck. Thank
18 you.

19 REPRESENTATIVE KELLER: But I'm
20 sorry, you know. I just wanted you know I had to
21 leave.

22 MS. ERICKSON: Hopefully you'll be
23 able to join us tomorrow for a little while.

24 REPRESENTATIVE KELLER: Oh, yes.
25 I'll be here.

1 MS. ERICKSON: Good. Right. The
2 future of the state is in balance. You can go.
3 Thank you.

4 And then we had describe our
5 process as being one of, continually, that we
6 couldn't just, all at once, get a picture of the
7 current condition of the system, that we were
8 continually working through a process of
9 understanding better the condition of the current
10 system to better inform, then, decisions related to
11 recommendations for both continuing to build the
12 foundation, our three pieces of the foundation --
13 health information, now infrastructure; health care
14 workforce, and statewide leadership.

15 And as we continued to build the
16 foundation, that we would be identifying strategies
17 and making recommendations about strategies that
18 will make the system more consumer-focused and the
19 health care delivery system more innovative to meet
20 the goals of improved value, decreased cost, and
21 increased quality, improved access, and making the
22 system more prevention-based.

23 So that's, just in general, our
24 strategy. And then in our 2010 report, we
25 identified what we had learned about the current

1 condition of the system in 2009, 2010, and listed
2 our study plans for calendar year 2011 -- health
3 care spending and cost drivers in Alaska, the
4 health care pricing and reimbursement study, the
5 health status of Alaskans, and then learning a
6 little bit more about some particular service
7 sectors -- long term care and the trauma system.

8 So those were the things that we
9 had listed we were going to learn more about during
10 this year. And then the strategies that we listed
11 that we were going to learn about to inform
12 recommendation development were the online
13 community health information system, patient-
14 centered medical homes more -- I mean, we studied
15 it in 2009 and had a high level, very global
16 recommendation. We're going to get down into more
17 detail. Price and quality transparency,
18 value-driven purchasing -- specifically payment
19 bundling and leveraging state purchasing power --
20 insurance regulations, consumer-oriented health
21 information, technology innovation, and then
22 measuring improvement in Alaska's health care
23 system.

24 So the way that we've been
25 structured so far -- and this doesn't mean we can't

1 change -- is that the learning sessions haven't
2 been structured to facilitate generation of
3 recommendations at the end of them; but learning
4 sessions related to strategies for change or policy
5 change, we would.

6 I like the idea of adding, if
7 nothing else, the so-what question at the end as
8 part of our conversation for the learning sessions
9 and trying to be flexible around other things.

10 And the health information
11 infrastructure discussion this afternoon was meant
12 to lead to broader thinking; and it went further
13 than I had anticipated, but it was really good, I
14 thought, and I think it was really helpful in terms
15 of coming up with next steps for recommendation
16 development.

17 I'm not sure, but maybe after I
18 sleep on it tonight, I'll have a better idea,
19 unless you all have some specific ideas. If we
20 purposefully want to leave off any discussion about
21 potential recommendations for any of the
22 learning -- one of the reasons we had done that is
23 if it's not framed in the context of looking at
24 solutions and what the potential solutions might
25 be, if we're grabbing pieces of information out of

1 a learning session, if we might inadvertently go
2 down a wrong path without having more time to
3 study, and taking a strategy that might come out of
4 that learning and do some more learning about it.

5 COL. FRIEDRICHS: So as a
6 urologist, bladder health is near and dear to my
7 heart, and I would encourage us to break at some
8 point here.

9 While I very much appreciate your
10 returning to this -- that was a diplomatic way of
11 approaching that subject -- what I would ask folks
12 to think about is, you know, other commissions that
13 I've been on, and we've brought folks in to speak
14 to us. We've said, "Here's what our charter is.
15 We're interested in learning about your area.
16 Speak specifically to these tasks that we have been
17 asked to accomplish, and give us your best
18 recommendations at the end. What is the industry
19 doing? What are the best practices that we should
20 be considering? so that as someone is speaking to a
21 commission, they understand the context in which we
22 are listening to their presentation.

23 That doesn't mean that we give
24 them the script, but at least they know what we are
25 thinking about as we're listening to them, and

1 hopefully they can speak to some of those specific
2 questions. Like, you know, health information
3 technology or infrastructure is a wonderful thing.
4 Where has it actually improved access?

5 I mean, I know some specific areas
6 in the federal system where it has improved access,
7 but we didn't touch on that in the presentations
8 today.

9 I think we can help ourselves be
10 more effective and efficient if -- and I'm throwing
11 this out for people to think about tonight -- if we
12 frame future briefings that we receive in that
13 context of here are the questions we've been asked
14 to answer as we prepare recommendations, and let
15 them come back to us with their best answers in
16 their particular area.

17 And then I move that we adjourn.

18 DR. LAUFER: Can I plug this New
19 Yorker article by Atul Gawande? It's January 24th.
20 Here are some copies. Because the first case here
21 is what happens when you go off the cliff. It's
22 about Camden, New Jersey. And, you know, they lost
23 half their police force for a while, and things are
24 bad. And, you know, hopefully we're never like
25 Camden -- if you've ever been there, it's a little

1 nasty -- but, I mean, they have already gone off,
2 and they said, "Hey, get a parachute."

3 MS. ERICKSON: We had not
4 distributed this, because Noah had just brought a
5 few copies. So this is the Hot Spotters, a New
6 Yorker article by Atul Gawande that came out in
7 January. I had distributed electronically earlier
8 articles that Dr. Gawande had published in the New
9 Yorker, but I hadn't forwarded this one. I have it
10 electronically. I'd be happy to share it with
11 anybody electronically, but if anybody wants it for
12 reading tonight or on the airplane home tomorrow,
13 Rich has those copies. Just raise your hand, and
14 he'll give you one right now. Okay. Very good.

15 Any final questions or comments
16 before we wrap up tonight? So we are getting
17 started right at 8:00 tomorrow morning, and we have
18 a large panel of folks coming to teach you about
19 long term care in Alaska.

20 DR. LAUFER: It sounds expensive.
21 (Laughter.)

22 CHAIRMAN HURLBURT: We will want
23 to try to break by 11:00 for those who need to make
24 their flights.

25 DR. LAUFER: The plane leaves at

1 12:30, so --

2 MS. ERICKSON: We will be
3 adjourning at 11:00 tomorrow. Thank you.

4
5 (Meeting recessed at 5:15 p.m.)
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1 FRIDAY, APRIL 1, 2011

2 8:02 A.M.

3
4 CHAIRMAN HURLBURT: It's a couple
5 minutes after 8:00, and we've got a full morning.
6 We want to be done by 11:00. We'll have the last
7 half hour that we'll need to save to do some wrap-up
8 and some planning regarding the commission, but the
9 first two and a half hours this morning, we want to
10 talk about long term care.

11 And we have a panel that's been
12 put together. We have seven folks here. Duane
13 Mayes, who is the Director of the Senior Disability
14 Services, put the panel together and will be
15 leading it. We'll have a series of presentations
16 and time for discussion.

17 But I wanted to put this slide up,
18 that Mark shared with us yesterday, both now and
19 before our decision. As Mark explained, the slide
20 goes out to 2020 but we have been living back here.
21 And when we think about health care costs, we think
22 about hospitals, we think about physician services,
23 we think about drugs and other things.

24 But the question -- Noah raised a
25 question yesterday: Can you always depend on these

1 projections? Well, no, of course you can't. You
2 never know for sure what the future is going to be;
3 but this is the best information that we have that
4 Mark has worked out for us.

5 And we see the hospital costs, the
6 physician costs, the pharmaceutical costs, all the
7 other things there. But the dramatic thing on this
8 is coming out of almost nowhere, you might say.
9 These are the costs for long term care. And so
10 this is our future as we know it now, as best we
11 can look at it.

12 And so one of the issues today
13 will be to talk about long term care and to make a
14 decision, as a Health Care Commission: Is this
15 something that we should be addressing, that we
16 should be looking at, making recommendations on
17 going forward, because it has not been an area that
18 the commission had addressed in the first couple of
19 years of its existence.

20 But this is where we are now.
21 This is where we're going. I think it's startling.
22 As I say, I'll put it up again to frame our
23 discussion when we have that.

24 So I'd like to turn it over to
25 Duane now. He'll introduce his panel and has the

1 program worked out on that. Thank you.

2
3 LONG TERM CARE IN ALASKA:
4 ISSUES AND STATUS

5
6 MR. MAYES: Good morning. Let me
7 get set up here. I have a little toy to play with
8 in case I want to point things out on the slides.

9 So for the record, my name is
10 Duane Mayes, and I'm the Director for the Division
11 of Senior & Disability Services. That division is
12 located within the Department of Health & Social
13 Services.

14 Today we have a total of six
15 folks, including myself, here to present on long
16 term care. You have in front of you a PowerPoint
17 presentation as well as what we have up on the
18 screen.

19 You'll see that we have several
20 folks that are here to present. We have Millie
21 Duncan, who is the Administrator for Wildflower
22 Court. And Millie is right there.

23 We have David Cote, who is the
24 Director for Pioneer Homes, and he is right there.

25 We have Denise Daniello, who is

1 the Executive Director for the Alaska Commission on
2 Aging, and she's right behind me.

3 We have Kay Branch, who is the
4 Program Coordinator for the Alaska Native Tribal
5 Health Consortium. Kay is right there.

6 And then we have Nancy Burke from
7 the Alaska Mental Health Trust. She's a program
8 officer and is quite involved with long term care
9 and housing for the trust. And she is right behind
10 me, right there.

11 And then we have Sandra Heffern,
12 who is the Chair of the Community Care Coalition
13 here in Alaska.

14 So those are the panelists, and
15 each one will be speaking to a particular area.

16 So I have to present and move
17 slides as well, so let me see if I can do this
18 correctly.

19 Okay. So this is our agenda for
20 today. I just gave you the introduction of who is
21 here. We're going to start out by talking about
22 long term care in terms of its definition. What is
23 long term care? We didn't want to just presume
24 that the commission knew all the details of what
25 long term care is, so we felt we should at least

1 start with a foundation of that and talk about who
2 is being served.

3 We want to then get into the
4 history of long term care to kind of give you a
5 scenario of what's happened over the last 20, 30
6 years and how did we get to where we are today with
7 long term care services.

8 We'll talk about what services are
9 provided and by whom, and this is where the
10 panelists will be coming up to the mike. And we'll
11 start out with skilled nursing facilities and have
12 a discussion about that, a presentation about that.

13 Pioneers Homes with David Cote.
14 Home and Community Based Services, and Sandra
15 Heffern is going to take the lead on that. Tribal
16 health with Kay Branch. And then I didn't put this
17 there, but Nancy Burke, with the Trust, will come
18 up and speak as well about housing and long term
19 care.

20 We'll have some discussion about
21 what is missing in the system. Denise Daniello,
22 with the Commission on Aging, will talk about the
23 senior survey and forums that they have held.
24 We'll have a discussion about long term care
25 housing needs, and then get into maybe some of the

1 details of what we see as needs for skilled nursing
2 facilities, Pioneer Homes, and home and community-
3 based services.

4 And then we'd like to kind of lay
5 out for you what the plan is for this group. This
6 group will be coming together over the next year,
7 and what does that mean in terms of future
8 activities? And then we'll open it for questions,
9 either from the panelists who may have other
10 thoughts that they want to share with you, or
11 questions from you as the commission. So that's
12 our agenda today.

13 Okay. So the first thing we want
14 to do is just talk about the definition of long
15 term care. So long term care is a variety of
16 services which help meet both medical and
17 nonmedical needs of people with a chronic illness
18 or disability who cannot care for themselves for
19 long periods of time.

20 It is common for long term care to
21 provide custodial and nonskilled care, such as
22 assisted living with normal daily tasks like
23 dressing, bathing, and using the bathroom, for
24 example.

25 Increasingly, long term care

1 involves providing a level of medical care. It
2 required the expertise of skilled practitioners to
3 address the often multiple chronic conditions
4 associated with older populations.

5 Long term care can be provided at
6 home, in the community, in assisted living, or in
7 nursing homes; so you have that range. Long term
8 care may be needed by people of any age who
9 experience a developmental, cognitive, or physical
10 disability, those with traumatic brain injury,
11 those with persistent and severe behavioral issues,
12 and seniors.

13 So we put this slide up to kind of
14 give you an idea of the continuum of care. It's
15 really just a visualization from home care all the
16 way to a higher level of acuity in terms of
17 hospital care. We thought this would be a nice
18 picture to show in terms of giving you that range.

19 So the history of long term care.
20 Ideas about the -- thank you. I see that my
21 multitasking is somewhat challenging.

22 Ideas about the best way to care
23 for the elderly and people with disabilities have
24 undergone dramatic changes in the past several
25 decades. The pendulum has swung towards in-home

1 care -- and I think that's key -- and greater
2 control over services by the recipient of care.
3 The initial step in this direction was the
4 provision of in-home services by home care agencies
5 that sent nurses, therapists, and aides into their
6 home to deliver both medically related home health
7 services and personal care.

8 Personal care assistance
9 encompasses help with activities of daily living,
10 which we refer to as ADLs -- and this is such
11 things as eating, bathing, and dressing -- and with
12 instrumental activities of daily living, such as
13 meal preparation, shopping and/or housekeeping.

14 So Alaska made a sea of change in
15 its public policy and public funding assistance in
16 about 1994, when Alaska joined the other 49 states
17 that had already added home and community based
18 care. And these are the waivers to their state
19 Medicaid programs.

20 Medicaid coverage of nursing home
21 costs has always been mandatory. I think that's
22 important to know. Once a certificate of need for
23 the beds has been granted, home care waivers then
24 can be -- were then added and still are optional
25 Medicaid services. Personal care assistance -- PCA

1 service is another optional Medicaid service, one
2 that Alaska chooses to rely on to further its
3 policy of funding less costly, less restrictive
4 care in lieu of allowing significant growth in
5 nursing home bed usage.

6 A majority of persons on home care
7 waivers receive PCA services as a vital component
8 of the care that allows them to stay home or stay
9 in their community. So that was the first sea of
10 change.

11 The second sea of change by Alaska
12 in the 1990s was the closing of the state's only
13 institution for the mentally retarded and
14 developmentally disabled, which we refer to as
15 Harborview, and that was located in Valdez.

16 As residents were transitioned out
17 of Harborview, they often initially lived in group
18 homes. Eventually, former residents of Harborview
19 and all future citizens needing similar assistance
20 are now being served in independent living settings
21 to the full extent possible for each person.

22 Finally, public policy shifted to
23 provide supports for gainful, mainstream employment
24 by persons with physical disabilities. So for many
25 hundreds of adults with physical disabilities, home

1 and community based services are what enable them
2 to get ready for work each day and to maintain
3 themselves in their own homes.

4 So Alaska currently has less than
5 half of the national average number of nursing home
6 beds per thousand people 65 years or older. With
7 just 20.4 nursing home beds per 1,000 seniors,
8 Alaska has the second fewest nursing home beds per
9 thousand people 65 years and over among the 50
10 states; so a very interesting fact.

11 Like seniors everywhere, many of
12 Alaskan seniors need some level of care to get
13 through the day. For many seniors, disabled adults
14 with chronic diseases and conditions, and children
15 with complex chronic medical needs, they are using
16 a variety of care, because they do not require
17 nursing home care.

18 Even more importantly, several
19 thousand seniors and other disabled Alaskans who do
20 qualify to receive nursing home care have a choice:
21 Medicaid home care waiver services. So including
22 PCA to stay out or move out of a nursing home, with
23 home care waiver services -- almost always
24 including PCA -- these Alaskans live in their
25 homes, the homes of family members, or in private

1 assisted living homes. If seniors and Alaskans
2 with chronic disabilities were not choosing PCA and
3 waiver services, or if adequate funds were not
4 available to fund home and community based
5 services, more Alaskans would move into nursing
6 home care.

7 Even if one chooses to ignore the
8 many other positive aspects of home and community
9 based services, Alaska cannot opt to meet seniors'
10 needs through nursing home care, because Alaska
11 currently does not have enough nursing home beds to
12 accommodate all of its seniors if home and
13 community based services was not available. So
14 Alaska would need to increase its nursing home beds
15 by over 1,200 beds just to reach the national
16 average level of beds per thousand seniors.

17 So that gives you a little bit of
18 an historical perspective and the definition of
19 long term care. I would like to invite Millie
20 Duncan, who is the Administrator for Wildflower
21 Court, which is here in Juneau, and I will be her
22 assistant in terms of the -- yes?

23 DR. STINSON: One question: Do you
24 have what the average cost is per PCA patient/client
25 versus a nursing home client?

1 MR. MAYES: Yes. Some more recent
2 data would -- and I don't have that in front of me,
3 so I'll give you an approximation: about \$24,000 a
4 year for the average cost of PCA services.

5 DR. STINSON: How about a nursing
6 home?

7 MR. MAYES: About \$86,000 a year.

8 MS. DUNCAN: Some of these first
9 couple of slides are just to give a little bit of
10 history on nursing homes and how they came about.
11 Before the great depression, the institutional
12 elderly were combined with other people that needed
13 long term institutional care. They weren't
14 separated.

15 And so with the Social Security
16 Act, it actually paved the way for nursing homes to
17 deal or care for strictly the people that needed
18 assistance with their medical needs in long term
19 care.

20 And so as time has grown and gone
21 on, nursing homes have changed from the type of
22 services that they used to provide, and there are
23 several reasons for that. One is because of
24 changes in health care needs; there has been
25 changes in the hospital reimbursement system; and

1 the development of home and community based
2 services and assisted living homes.

3 So this shows the causes of death
4 over the last century, and pneumonia and influenza
5 was the major cause of death early in the 1900s.
6 The big spike was the flu of 1918. And then this
7 removes the flu and influenza. So these two slides
8 show that what people died of in the early part of
9 the century were acute illnesses.

10 And as time has gone on, chronic
11 disease has become more and more prevalent for
12 causes of death, and those chronic diseases are
13 causing people to need more care than what we had
14 at the beginning of the century.

15 The changes in the reimbursement
16 system have not only affected nursing homes, but
17 they have also affected home and community based
18 services. In the past, hospitals were paid in a
19 different manner. And in the mid 1980s, Medicare
20 introduced a payment system so that hospitals were
21 paid based on their diagnostic groups. And so the
22 incentive became to discharge people from the
23 hospital earlier than what they did in the past.

24 And so what happens is that
25 nursing homes are getting people that are more and

1 more acutely ill, and also home and community based
2 service are also getting more demand to care for
3 people that are more ill.

4 Because of these changes, there
5 has been a huge growth in home and community based
6 services. They have also developed a lot of
7 medical technologies that can be used in the home
8 now, and the people that used to be in a nursing
9 home are no longer appropriate for nursing home
10 level of care. They're really home and community
11 based care.

12 So this was a study that the
13 Kaiser Commission completed in 2007. It shows the
14 year 1999 compared to the year 2004; and just
15 looking at the major chronic illnesses of COPD,
16 stroke, and diabetes care, and seeing how the
17 growth changed from 1999 to 2004. And this is
18 among nursing home residents.

19 Then for just Wildflower Court, I
20 pulled out our statistics from 1996 all the way
21 through 2010. And when we admit residents, we have
22 a diagnosis that is assigned to them, based on what
23 their illnesses are. And the growth in residents
24 that have nine or more diagnosis codes has grown
25 quite a bit in the last few years.

1 We're also, in nursing homes,
2 dealing with mental health issues. And this is,
3 again, the Kaiser study, highlighting the year 1999
4 and the year 2004; and it shows people with
5 dementia, schizophrenia, depression, and other
6 affective disorders. So nursing homes are not only
7 dealing with people with physical disabilities; we
8 also have a high level of people with mental
9 illnesses.

10 And so I also did the statistics
11 of those same diagnoses from Wildflower Court for
12 the years 2000 through 2010, and you can see quite
13 a growth then in our dementia, depression, and
14 other serious disorders. And then the green line
15 there is the percentage of residents with one or
16 more mental health diagnoses.

17 Also, nationwide -- but I didn't
18 have any statistics for nationwide -- but there is
19 a growth in the change for residents that nursing
20 homes have become more of a rehab center, where we
21 treat and provide care, with the goal to discharge
22 a person home.

23 So, again, just statistics from
24 Wildflower Court. You can see on the top graph how
25 our number or percentage of residents that we're

1 discharging home has grown more each year.

2 And then the variety of things
3 that we are doing has increased too. So that's the
4 second graph, which shows that we're doing rehab
5 following acute illnesses, following stroke,
6 following cancer treatments, following surgery.

7 And so residents come to us from
8 the hospital, and we're doing the care that
9 hospitals used to do many years ago in getting a
10 person ready to discharge home. We're very strong
11 supporters of home and community based services,
12 because that gives us a place to discharge someone
13 to; and then we can move on to the next person that
14 needs our help.

15 And then this last slide shows,
16 again, the demands. This is a national study that
17 was done by the American Health Care Association.
18 And because of the increase in acuity, the mental
19 health issues, and the rehab work that is being
20 done by nursing homes nationwide, the amount of
21 staffing that is needed in hours per resident day
22 has increased nationwide.

23 And I don't have any statistics
24 for Wildflower Court, but I'm sure that we have
25 also had to increase our number of staff per

1 resident day as well.

2 MR. CAMPBELL: Question.

3 MS. DUNCAN: Yeah.

4 MR. CAMPBELL: Do you think that
5 your statistics vary very much from most of the
6 other institutions in the state of your class?

7 MS. DUNCAN: I don't think so.
8 Maybe Pat could -- because he's got a nursing home
9 too.

10 MR. BRANCO: No. These seem
11 perfectly aligned with our numbers as well. And
12 broadly based across the state, I don't hear any
13 differences.

14 MS. HALL: When you talked, in one
15 of your slides toward the end, about an increasing
16 number of multiple procedure codes that you're
17 seeing, is there any relationship in that and just
18 the increasing number of procedure codes that are
19 available today?

20 MS. DUNCAN: No. There is an
21 increase in the number of codes because CMS, the
22 Centers for Medicare and Medicaid Services, are
23 wanting us to be more finite in what we do. But it
24 just -- it narrows it down to a more specific
25 definition. And so there are more codes, but

1 instead of just saying "dementia," it's now
2 "dementia caused by this" or "dementia because of
3 this" or something. So you still have to pick a
4 specific reason.

5 MS. HALL: Okay. Thank you.

6 MR. MAYES: Our next presenter is
7 David Cote with the Pioneer Homes. He's the
8 Director for the Pioneer Homes.

9 MR. COTE: Good morning. And
10 again, as Duane just said, my name is Dave Cote,
11 Director of Pioneer Homes.

12 And as the slide up there shows,
13 the Pioneer Homes consist of six homes located in
14 Anchorage, Fairbanks, Juneau, Ketchikan, Palmer,
15 and Sitka.

16 And we are a provider of
17 residential assisted living, and we're -- we have a
18 508-bed license capacity, and we stay at about a
19 93 percent occupancy rate, pretty much consistently
20 over the years.

21 We have three levels of care. The
22 Level I provides housing. It provides meals,
23 laundry services, and emergency services when
24 needed. These people are pretty much on their own.
25 They are able to take care of themselves. They

1 don't need assistance with activities of daily
2 living.

3 And so then that contrasts with
4 our Level II, where you get the same services,
5 except, in addition to that, you get assistance
6 with activities of daily living pretty much during
7 your awake period of time, and pretty much not
8 during the nighttime.

9 And then our Level III service is
10 all of that again, only these people need
11 assistance 24 hours a day, seven days a week; and
12 they are very, very close to what I would call a
13 nursing home level of care.

14 We're a provider of -- we
15 specialize in Alzheimer's and related disorders,
16 and we have about -- over the years we've varied
17 between 56 and 59 percent of our total population
18 has some form of ADRD, of Alzheimer's related
19 disorders.

20 To get into a Pioneer Home, you
21 have to be 65 years or older, and you have to be a
22 resident of the State of Alaska for the previous 12
23 months, and you need to be in need of the services
24 of the Pioneers Homes.

25 Then the next slide shows -- this

1 contrasts over the next -- in the last 15 years, we
2 have seen a radical increase in our Level III,
3 which is our highest level of care. It's gone from
4 25 percent in '95 to 57 percent in 2010. In
5 contrast, we have seen a decrease in our Level I
6 from 37 percent to 12 percent.

7 So 15 years ago, what you had was
8 you had seniors who were coming and going. They
9 had their own cars. Parking used to be a problem
10 for us. These people were out and about in the
11 community. Nowadays, what we are seeing is people
12 are not able to do that. And so, like I said, we
13 look very much like a nursing home.

14 Now, on the wait list, one of the
15 concerns that I've had is that our wait list keeps
16 going up. As of December 31st, we had 356
17 unduplicated people on our active wait list.

18 I should differentiate that there
19 are two wait lists that we have. There is an
20 active wait list, which means you need the services
21 of a Pioneer Home within the next 30 days -- so you
22 are ready to come in at that point -- compared to
23 the inactive wait list, which means "I might want
24 to come into the Pioneer Home. I'm an Alaska
25 resident. I have the option to do that, but I'm

1 not ready yet at this time. But I'd like to put my
2 place in the queue."

3 How it works is we offer vacant
4 beds to the person with the oldest application
5 date. So tell everyone who is 65 years and older
6 to get on the wait list. It doesn't cost you
7 anything. And you may need it; you may never need
8 it. Hopefully you don't, but it's an option that
9 you can exercise should events in your life become
10 so that you need the services of the Pioneer Home.

11 So, anyway, as you can see, there
12 was a big decline from 1995 to 1998. What I would
13 attribute that to is the efficiency, the
14 effectiveness of home and community based services.
15 People don't really want to come into an
16 institutional-type setting. They'd rather stay in
17 their community. They'd rather stay in their own
18 home. And so we see -- we saw that decline in the
19 need for a Pioneer Home because the home and
20 community based services were doing an excellent
21 job of keeping people in their own home.

22 Then it stayed kind of up and down
23 until 2004, and what we would attribute that to,
24 the increase, is we conducted some outreach efforts
25 back then. We were trying to get the word out

1 about the Pioneer Home and to let people know. And
2 that caused an interest and people signed up, so
3 there you have it.

4 And then there was another
5 outreach in 2008 kind of primarily targeted toward
6 Native folks and rural folks. We noticed that
7 there weren't a lot of people who were coming in
8 from rural Alaska, so we thought that we should
9 get, you know, the word out about that.

10 Our Level I rate -- the rate we
11 charge is \$2,350 per month, and that's based on --
12 it's just a month, so a 28-day month is the same as
13 a 31-day month. Our Level II is \$4,260 per month,
14 and our Level III is \$6,170 per month.

15 And so, anyway, one of my concerns
16 is that we have got all these baby-boomers who are
17 becoming seniors, and they are going to start to
18 present for services. And so I'm concerned that
19 our wait list for active and inactive is going to
20 continue to rise. And I should point out that on
21 the inactive wait list, we have 3,025 unduplicated
22 clients.

23 And that's my presentation.

24 MR. MAYES: Thank you.

25 REPRESENTATIVE KELLER: Dave, can I

1 ask a question?

2 MR. COTE: Yes.

3 REPRESENTATIVE KELLER: I just
4 noticed -- I should have known this before -- but
5 your Level III, that is not considered a nursing
6 home bed, then?

7 MR. COTE: No. We offer assisted
8 living.

9 REPRESENTATIVE KELLER: Just
10 assisted living?

11 MR. COTE: Yes.

12 REPRESENTATIVE KELLER: I was
13 always, wrongly, under the impression that the
14 Level III were counted with the nursing home beds.

15 MR. COTE: It's extremely close,
16 but it's really a matter of how we choose to be
17 licensed. If we became a nursing home, we'd have to
18 meet all these additional licensing requirements;
19 and so we've chosen not to go that route.

20 REPRESENTATIVE KELLER: Thank you.

21 MR. MAYES: Our next presenter is
22 Sandra Heffern.

23 MS. HEFFREN: Good morning. Happy
24 April. It's April 1st.

25 So I feel like I get to be the

1 shining star of home and community based services.
2 Also I think I might be the bane of the existence
3 because of rising costs of home and community based
4 services.

5 So, again, my name is Sandra
6 Heffern, and I'm here as the Chair of the Community
7 Care Coalition. The Community Care Coalition
8 consists of trade associations that work with
9 seniors and people with disabilities: The Alaska
10 Association on Developmental Disabilities, the
11 Alaska Behavioral Health Association, AgeNet, the
12 Assisted Living Home Association of Alaska, and the
13 Personal Care Assistant Providers Association of
14 Alaska. We all banded several years ago to have a
15 united voice for the home and community based
16 service delivery model.

17 We represent, in practically all
18 of the communities in the state of Alaska, about
19 50,000 consumers, family members, staff, et cetera.

20 Again, I'm presenting today on the
21 home and community based component of long term
22 services and supports. We cover a vast array of
23 services and supports, and so I'm going to just
24 have Duane go ahead and list out all of these so
25 you can look at the variety of services that are

1 provided in the home and community based model.

2 Some of them are very labor-
3 intensive. I think all of them are labor-
4 intensive, but some of the services are minimal as
5 far as the intervention that we're providing with
6 consumers, and some are more skill-intensive.

7 The services that I think, when
8 people are first involved in the home and community
9 based model, tend to be the most effective are the
10 homemaker and chore services. I know that for some
11 consumers, when they first start needing services
12 and supports at home, the first thing that goes is
13 your ability to keep your house clean, you know,
14 and providing a little bit of chore services can go
15 a long way in providing -- in expanding or
16 extending the amount of time that somebody is
17 allowed to be at home.

18 Again, I think that what we need
19 to talk about with home and community based
20 services is -- and I hate to always, when I'm
21 giving this type of a presentation, start talking
22 about funding; but I think it's important for
23 people to know -- and I know that Representative
24 Keller is very aware of this -- but I think it's
25 important for people to know how these services are

1 paid for.

2 We've talked about that there are
3 four waivers in our state, home and community based
4 waivers. There is the Older Alaskans waiver, which
5 provides services for people over the age of 65.
6 There is the Adults with Physical Disabilities
7 waiver, which is for adults 18 to 65. The MRDD
8 waiver, which is changing to I think the IDD
9 waiver -- I'm not quite sure. But it's Mentally
10 Retarded or Developmentally Disabled, and it's
11 going to intellectually disabled or cognitive
12 disabilities. I'm not quite sure. I haven't
13 followed that one that close as far as what the new
14 terminology is. And that's for both children and
15 adults.

16 And then the CCMC waiver, which is
17 for children with complex medical conditions up to
18 the age of 22.

19 As Duane had talked about, there
20 is also not a waived service, but a regular
21 Medicaid service, and that is personal care
22 assistant services. A little bit later I'll get
23 into who the providers of those services are.

24 Some of the home and community
25 based long term services and supports are designed

1 to provide the support needed to allow a person to
2 remain in their own home, while others are designed
3 to improve skills and/or functioning.

4 So under the MRDD waiver in
5 particular, you have services that are habilitative
6 in nature. It means that the purpose of those
7 services is to actually teach skills so that a
8 person can be as independent as possible.

9 Same thing with things like
10 psychosocial rehabilitation that's provided for
11 individuals with severe and persistent mental
12 health concerns. Those services are designed to
13 enhance a person's ability to live, work, and play
14 in their community.

15 The day habilitation, supported
16 employment, those types of services, again, are to
17 build skills for individuals with developmental
18 disabilities.

19 I think when Duane was putting
20 together this PowerPoint presentation that he left
21 out one of my slides. And I think he did it on
22 purpose, you know, quite honestly, because I think
23 he didn't want to scare you with the number of
24 providers of services in our state.

25 So, if you will, bear with me as I

1 go through some of the numbers of providers of all
2 of these services. You know, again, the last two
3 slides have just been a list of all of the services
4 that are covered in home and community based
5 services. So let's talk about who is providing
6 those services.

7 So within our state, there are
8 senior community based grantees. Now, those
9 grantees serve about 22,000 consumers. There are
10 12 adult day programs. There are 19 senior in-home
11 grantees. There are 14 providers of the National
12 Family Caregiver Support Program. There are 2
13 senior rural residential service providers, and
14 then grantees -- senior service grantees for meals,
15 home-delivered meals, and senior rides, there are
16 60 of those. And again, these are statewide
17 numbers.

18 Develop disability grantees --
19 they serve approximately 1,200 recipients. There
20 are 27 DD grantees, and then there are 12 providers
21 of short-term assistance and referral. Those are
22 STAR grants, is what we call those. There are 7
23 aging and disability resource centers. And then
24 there is another program, General Relief, which
25 serves about 960 people. So those are grantees.

1 Then we look at Medicaid home and
2 community based providers who serve about 6,100
3 people. Personal care assistant -- remember that
4 first chart -- there are 71 providers of PCA
5 services serving over 4,000 people annually.

6 Care coordination agencies --
7 under the Medicaid waivers, there is a requirement
8 that there is a -- that every individual who
9 receives a Medicaid waiver has to have a care
10 coordinator. That person is responsible for
11 assisting with assessing the need for services;
12 working with the consumer, their family, and other
13 team members to look at what kind of service
14 package that person needs; and then helping to
15 broker those services. In our state, there are 133
16 care coordination agencies with 337 certified care
17 coordinators.

18 There are 253 assisted living
19 homes -- or, excuse me -- 253 certified provider
20 agencies of assisted living, operating 621 homes.
21 That's a lot of homes. And then general waiver
22 service providers, there's 274.

23 Now, again, look at the list of
24 all the services, and 274 providers throughout our
25 state that are providing those services.

1 Then there is also private pay
2 provider companies. They take private pay. You
3 know, they take cash or long term care insurance.
4 The Veterans Administration also provides home
5 health care in its medical program and limited PCA
6 and respite services.

7 There are 40 mental health
8 providers in our state. You know, these are mental
9 health clinics or mental health centers. We have
10 licensed home health care agencies. We have
11 licensed hospice agencies. We have boards and
12 commissions, like the Mental Health Trust
13 Authority, the Commission on Aging, the Governor's
14 Council on Disabilities and Special Education, the
15 Mental Health Board, the Suicide Prevention Board.
16 And then there's also the State Independent Living
17 Council, Vocational Rehabilitation, locally
18 sponsored and supported senior centers, and I'm
19 going to stop at that point.

20 My whole point in going through
21 the number of providers is looking at not only do
22 we provide a vast array of services, but we also
23 have a large number of providers that are all
24 businesses that are out there providing services.
25 The most recent Trends magazine, through the

1 Department of Labor and Workforce Development --
2 and it was just published for March. The title of
3 it was "Social Assistance," which are social
4 services. The majority of home and community based
5 providers fall under that social assistance
6 category. I think they listed out 8,925 employees,
7 people that are working, that are getting jobs
8 through this -- through the home and community
9 based model of services and supports; so about
10 3 percent of the total population of the state of
11 Alaska.

12 So as we're talking about long
13 term services and supports, of course we're talking
14 about the services. Nobody likes to look at it as
15 a jobs program unless you're one of those
16 employers, unless you're one of those providers.

17 I'm a former owner of a home and
18 community based agency, and we were the 32nd
19 largest employer in the state. So we provided an
20 awful lot of jobs. I think the other part of it is
21 that the monies that are earned by those employees
22 stay in the state of Alaska. You know, these are
23 employees in all of our communities throughout the
24 state. They earn those dollars here, and they
25 spend those dollars here. So I think that's an

1 important thing for people to keep an eye on as
2 we're looking at this entire industry.

3 Let's see. I would end with:
4 Although home and community based services -- you
5 know, we see the spike in the waivers and PCA. As
6 time goes on, we see the spike in the cost. I
7 would reinforce what the other presenters have
8 said, that if we see major cuts in either waiver
9 services or in PCA services, that we're going to
10 see that cost shifting into more costly service
11 delivery.

12 Home and community based services
13 make sense from a cost perspective. They also make
14 sense from a human perspective. I think people
15 really like to wake up in the morning to the smell
16 of their own coffee rather than somebody else's.

17 So thank you.

18 MS. HALL: Can I ask a question?

19 MS. HEFFREN: Sure.

20 MS. HALL: When you describe what
21 sounds like an extremely large array of individuals
22 or agencies providing these services, is there
23 any -- this will tell my background, won't it? -- is
24 there any regulatory oversight? Are there
25 requirements for licensing, or can you just become a

1 peer support because you want to?

2 MS. HEFFREN: Thank you. There are
3 licensing requirements for assisted living homes in
4 particular. There are certification requirements
5 for all of the waived services and for PCA
6 services.

7 I think that the other part of
8 that question that I'll add to for you is not just
9 is there the licensing and certification and
10 regulatory, but is there communication among those
11 providers? I mean, I look at the number of
12 providers in our state for the number of our
13 population, of our total population, and I question
14 whether there is some synergy that we could
15 implement that would be more efficient, you know,
16 in how we deliver services that would help reduce
17 some of the administrative cost.

18 MS. HALL: Thank you.

19 DR. LAUFER: I don't know if you
20 can hear me. Do you have any sense of the trend
21 away from families caring for their elders? You
22 know, I cared for my grandfather. My dad lives with
23 my sister. There is no compensation or anything.
24 And it seems like this is -- as a family doc, this
25 is becoming rare.

1 I'm also really curious about the
2 people who do but are somehow reimbursed; and I
3 don't know how that works, but I see that as well.

4 MS. HEFFREN: Well, I think that
5 one of the trends that I think everybody has seen is
6 the nuclear family is not as nuclear as it used to
7 be. Exactly. You know, so the opportunity -- well,
8 and it's also that there's more women in the
9 workforce. It used to be that, you know, it's like
10 families were intact. The women stayed at home, and
11 they took grandma and grandpa or the child with a
12 disability, et cetera. So I think we have seen a
13 move away from that.

14 I was struck yesterday by Mark's
15 presentation when he talked about that we
16 measure -- we manage what we measure. One of the
17 things that I think we don't have a good handle on
18 is the number of family care providers that are out
19 there. There are thousands and thousands of hours
20 of unpaid work that's happening, you know, and it's
21 very difficult for us to have a handle on that.

22 MS. DUNCAN: Could I add to what
23 you're saying too? The increase in chronic
24 illnesses, too, have really affected that too.
25 Where a family could manage at home before, they

1 really can't anymore.

2 MS. HEFFREN: Thank you.

3 MR. MAYES: Okay. Our next
4 presentation is Kay Branch with the Alaska Native
5 Tribal Health Consortium. Kay?

6 MS. BRANCH: Thank you. I do elder
7 care planning for ANTHC, and I've worked with Alaska
8 Native elders for about the last 18 years in
9 different capacities. And I'm very happy to be
10 here.

11 And to address that last question,
12 in Alaska Native communities, this, too, is
13 happening. But also what we're seeing is more
14 people needing to go into the cash economy, and so
15 some of that does get disbursed. But I certainly
16 have seen many people cared for in their own home
17 that are very compromised in their health.

18 DR. LAUFER: Thank you.

19 MS. BRANCH: So I want to talk a
20 little bit about ANTHC's role in long term care and
21 sort of how that has developed over the last several
22 years.

23 First of all, we jointly manage
24 the Alaska Native Medical Center; and through this,
25 we sort of look at long term care as one part of

1 the continuum of care, because we're in a -- we
2 manage a hospital. We've got to do something
3 with -- to discharge patients. We really can see
4 that having a well-developed long term care system
5 can help actually decrease some of those hospital
6 costs that we're seeing.

7 If you have a well developed
8 system, you don't have to end up, first of all,
9 keeping people in the hospital for longer than they
10 need to be there, which is what we actually are
11 seeing right now. People have to remain in the
12 hospital because there isn't a place to discharge
13 them. We're already seeing the effect of the
14 downsizing of Providence extended care in Anchorage
15 and are having difficulties in placing people in
16 nursing home care -- we do do assisted living --
17 and then in the rural areas, because of the lack of
18 services.

19 So we're already struggling. It's
20 like how do we more efficiently look at that
21 service over the whole continuum so we can
22 decrease -- also decrease rehospitalizations by
23 providing the kind of care that people need upon
24 discharge to be able to return to their, you know,
25 highest ability and function.

1 We also play a role, a very large
2 role, in the coordination of tribal health around
3 the state. ANTHC is actually a voluntary
4 organization. We've got probably a little over 30
5 members who are all tribal health organizations,
6 and they've signed as part of our compact with the
7 federal government. And we provide sort of the
8 ancillary services that used to be provided by the
9 Area Office of Indian health.

10 And one of those services is
11 actually to coordinate what is going on around the
12 state. And so what we do, we have several
13 committees that -- and I'm just going to highlight
14 three committees right now, because these are the
15 committees that primarily I'm working with for long
16 term care issues: The Alaska Tribal Health System
17 Long Term Care Committee -- and this is about 50
18 people. They don't all come. Right now, we are
19 meeting every two weeks, because of the things that
20 are happening within the state, to figure out how
21 we can increase long term care services to our
22 Alaska Native population throughout the state.

23 I just got off of two days of
24 meetings with the Alaska Native Elder Health
25 Advisory Committee. And these are appointed by

1 their tribal organization. We have 13 members, and
2 they provide -- they serve in an advisory capacity
3 about services, recommendations, and processes for
4 the ANTHC Board of Directors.

5 Also -- and I think this one is
6 very critical -- is the medical services networking
7 committee, which includes the clinical directors
8 committee. And these are folks who meet quarterly.
9 These are the clinical directors of the tribal
10 health organizations and the hospital and health
11 care administrators of the organizations. And they
12 have long term care as a standing agenda item, and
13 so I am there at all of their meetings sort of
14 updating them.

15 They do sharing of information
16 back and forth about maybe different ways that the
17 health organizations are providing services so we
18 can see sort of some best practices and then share
19 that at that level of leadership within the
20 organizations to hopefully expand and move forward
21 and create some more synergies around the state.

22 The other thing that I do want to
23 mention is that we do focus on both home and
24 community based and residentially based care,
25 because we have very few specific facilities for

1 Alaska Native people. We do look at that. We also
2 recognize that people want to be at home, if they
3 can be at home, and we want to support that. And
4 we want to be able to support the families who are
5 working hard to maintain their loved ones at home
6 for just as long as possible.

7 This is the Alaska Native
8 population. I wanted to let you though that we are
9 also participating in that senior boom. Alaska
10 Native people are also living longer; and in 20
11 years, that number will more than double for the
12 people over the age of 65.

13 And the majority of folks actually
14 do still -- the over-65 folks do still live in the
15 rural and remote areas of Alaska, and they are
16 being cared for by their families. In some cases,
17 we are having some home and community based
18 services out there, and there are a couple of
19 facilities out in the rural areas that are
20 providing care as well.

21 What we're seeing, again, is the
22 more migration into the urban communities. And
23 sometimes it may be someone in their 40's who comes
24 in and then turns 65, but perhaps they needed to be
25 near the specialty doctors that are housed at ANMC,

1 and they needed to be closer to that level of
2 medical care.

3 There is also family and economic
4 factors. Because of the economy out in the rural
5 areas, it's often difficult for families to stay
6 out there. So I got a call recently from a
7 granddaughter who had moved her grandmother out to
8 Anchorage about ten years ago, and her family was
9 looking after her. And they come to the place
10 where they could no longer do that. So, you know,
11 there wasn't an option for this grandmother to go
12 back out to her community, so they were looking for
13 somewhere for her here in Anchorage.

14 We also see a significant need for
15 long term care services among younger disabled
16 Alaskan Native people. And we see this through
17 discharge data from ANMC and other hospitals. We
18 also see it through Southcentral Foundation's Care
19 Coordination Program and the number of people they
20 serve on a Medicaid waiver who are under the age of
21 65.

22 Also -- and I know Millie had --
23 I'm not sure if she mentioned it here. She
24 mentioned it yesterday -- we're seeing a higher
25 number of people under 65 in our nursing homes as

1 well. I know at Providence Extended Care, they
2 actually have -- 40 percent of their residents are
3 under the age of 65.

4 I really want to emphasize that
5 the Indian Health Service has not historically
6 funded long term care, because I think this is
7 something that people assume that the Indian Health
8 Service covers, and they don't. They have not.
9 The Indian Health Service when it began really
10 focused on acute care, maternal/child health,
11 immunizations, and that sort of thing.

12 As Alaska Native and American
13 Indian people have, you know, been living longer,
14 tribes all over the country are struggling with
15 this issue: How do we provide long term care?
16 There is a commitment to provide for care from
17 cradle to grave, is the way that I've heard it
18 called, but there is not any funding from IHS.

19 And even though in the recent
20 reauthorization of the Indian Health Care Act, it
21 includes language that allows for long term care.
22 It doesn't include extra funding. And so still the
23 amount of funding that's provided by the Indian
24 Health Service really only meets 51 percent of the
25 need for basic health care services. And so people

1 can't shift money into long term care.

2 So tribal organizations around the
3 country are looking at Medicaid, Medicare, VA,
4 private payment to build their long term care
5 service capacity so they can still care for people
6 either on their own reservation or in their own
7 homes, or at least in facilities that honor the
8 culture of tribal people.

9 And there are a couple of benefits
10 to the state, and this is what we've been working
11 on for the past several years. What happens is
12 that, you know, normally -- and I'm sure you folks
13 know this -- that the state general fund Medicaid
14 pays about half the cost. I think it's going to be
15 a little bit more than half the cost -- for any
16 Medicaid dollars that are spent in the state. But
17 if the services are provided by tribal health
18 organizations to tribal beneficiaries, that money
19 comes entirely from the federal government. And so
20 it does not require a state match.

21 So, in closing, I'll just talk a
22 little about the challenges and gaps in long term
23 care services in Alaska. First of all, we know
24 there's a lot of providers. We heard that from
25 Ms. Heffern; but, really, the home and community

1 based services are not widely available in the
2 rural areas of our state. And there are a variety
3 of reasons for that. There was some changes about
4 five years ago in some of the regulations, and when
5 the Medicaid costs for PCA spiked up so high and
6 tribal organizations -- I know the Yukon Kuskokwim
7 Health Corporation has really hung on to their PCA
8 program and steadily provided services through that
9 time, but they have had to do that at a \$400,000
10 subsidy from their organization per year.

11 And so other organizations don't
12 have that money to add to the pot to actually
13 provide those services. There have been some
14 change in those regulations that are -- now the
15 rates do allow for a geographic differential.
16 These went into effect a month ago. That's why my
17 long term care committee is meeting every two
18 weeks. We want to see what we can get done and
19 what we can get done fast. And we are committed to
20 working with Duane and the folks at Senior Services
21 to make this happen.

22 There are also a few options for
23 residential care and long term care in rural
24 Alaska. We have a nursing home in Nome. There are
25 assisted lives homes in Kotzebue, Dillingham, and

1 Tanana, and they all do require a subsidy because
2 of the higher costs of care and living in these
3 rural areas.

4 And we do have funding now -- the
5 state provided funding last year -- for an assisted
6 living home in Bethel, which will open in October
7 of 2012; and the nursing home in Kotzebue, a wing
8 that's added on in Kotzebue. It will be 18 units,
9 and it will be finished in October of this year.
10 It's -- I was there. They are actually putting the
11 furniture in now. So it's pretty exciting.

12 And we still -- our legislative
13 priority is funding for the facility in Anchorage.
14 We have partial funding for that, and we would like
15 to see the additional funding so we can move
16 forward with that.

17 Thank you.

18 MR. MAYES: Any questions for Kay?
19 Okay.

20 Our next presenter is Denise
21 Daniello with the Commission on Aging.

22 MS. DANIELLO: Do people need to
23 stand up for a minute? I mean, we've been talking
24 at you. Maybe we should just stand up for a second.
25 Yes. Stand up. Stretch a little bit. And I can

1 begin talking, and you can listen as you're walking
2 around.

3 So my name, again, is Denise
4 Daniello, and I'm the Executive Director for the
5 Alaska Commission on Aging. And for those of you
6 who don't know about the commission, we're a state
7 agency under the Department of Health & Social
8 Services. Our charge is to plan, educate, and
9 advocate on behalf of all older Alaskans.

10 In statute, we are charged with
11 the responsibility of providing budget and policy
12 recommendations to the Governor, to the
13 Legislature, and to the administration concerning
14 programs and services that promote dignity,
15 independence, and quality of life for all older
16 Alaskans and their caregivers, and to make sure
17 that seniors and elders have access to these
18 services as close as possible to home in the least
19 restrictive setting.

20 Like you, we have a board of
21 directors, and we have 11 commission members on our
22 board. We have -- most of these individuals are
23 seniors, people age 60 years and older. There are
24 six of them. And the remaining seats are
25 designated for the Department of Health & Social

1 Services. Duane Mayes serves on our commission,
2 along with a representative from Commerce,
3 Community and Economic Development, and the Pioneer
4 Homes, and we also have a provider seat.

5 So this graph shows the growth of
6 the Alaska senior population. Now, it shouldn't
7 come as a surprise to too many of you that Alaska
8 has the fastest -- is the state with the fastest
9 growing senior population. And for those of you
10 who came here back in the 1970s like I did or
11 earlier, we know the state to be much different
12 back then.

13 It was basically a much younger
14 population of people in their late 20s. But during
15 the 1970s, during the oil boom of the 1970s, there
16 were a lot of young people who moved to the state
17 in order to get jobs, gainful employment, and for
18 other purposes as well.

19 And in contrast to earlier
20 generations of people who moved here, they
21 remained. Maybe some of us who are sitting in this
22 room are part of that early migration. And so they
23 are contributing to the growth of the senior
24 population.

25 The senior population, people aged

1 60 years and older, number about 85,100. For the
2 65 and older, it's 53,200 people. Seniors comprise
3 about 12.3 percent of the state's total population.
4 In comparison to the U.S., we're growing at a much
5 faster rate over the last ten years. I think the
6 senior population in the U.S. grew by about
7 13 percent, while here in Alaska it was closer to
8 50 percent over the last ten years; so it has been
9 an enormous boom.

10 Most of the growth in the senior
11 population is happening at the two ends of the
12 continuum. The fastest growing part of the senior
13 population is the people in the age categories of
14 60 to 64. So this, you know, the beginning of the
15 baby boomers entering into their senior years. And
16 this population of people are doing really well.
17 Most of them are healthy. They are working. They
18 don't need long term care services, for the most
19 part.

20 However, the other segment of the
21 senior population that is growing almost as fast
22 are the people who are 85 years and older. Now,
23 they don't number too many right now, but they're
24 growing really quickly. There's about 5,000, over
25 5,000 people in that age category, and they are the

1 ones -- the people who are the most in need of long
2 term care services. They are most likely to be
3 frail, be at risk for developing Alzheimer's
4 disease and related dementia, and have high health
5 care needs. And so that's the growth of the long
6 term care services for the senior population.

7 In comparison to the youth
8 population, seniors are growing much faster. For
9 kids age 18 years and younger, that growth in the
10 population is occurring at about 4 percent; but for
11 the seniors, people age 60 years and older, it's
12 going at 53 percent. So, big difference between
13 young and old people in our state.

14 DR. LAUFER: Can I just ask
15 hopefully a quick question? Is there any data or is
16 there any feel for the snowbirders seniors? The
17 season for the tan returning senior is approaching
18 quickly in our clinic, and we see a lot of people
19 who are here sort of transiently. And I always
20 wonder -- you know, they are able, they are
21 relatively affluent, and they are on Medicare; but
22 how does that play into the statistics for the
23 state? Or do they leave permanently?

24 MS. DANIELLO: Well, the people who
25 like to leave the state during the cold months,

1 that's usually probably maybe two or three months
2 out of the year. I think they are still included in
3 that senior population trend, because they are still
4 considered to be permanent residents.

5 DR. LAUFER: Will it blunt some of
6 that growth trend? I mean, you know, they often
7 will stay in Arizona when it gets harder. I guess
8 it makes your bones hurt. That's what I hear.

9 MS. DANIELLO: Yeah. Well,
10 according to the state demographer, what he says is
11 the out-migration of seniors is still higher than
12 in-migration of seniors, first of all. However,
13 that rate of leaving the state is slowing down. And
14 that if you ask seniors -- and we have, many
15 times -- what their plan is for the next ten years
16 in terms of where they want to live, it's Alaska.

17 DR. LAUFER: Wow.

18 MS. DANIELLO: It's not Arizona.
19 And the reason for that, I believe, is because their
20 home base is here. They have their families here,
21 they have their friends here, they have their homes
22 here. Their life is here. Plus it's a wonderful
23 place to live.

24 And so some of them do go south to
25 see, you know, because they think, "Well the grass

1 is always greener on the other side." But once
2 they get outside, they don't have those same family
3 and friends that they have here. And when you're
4 older, it's more difficult to establish those
5 friendships, and so that becomes really important.

6 DR. LAUFER: Thank you.

7 MS. DANIELLO: Okay. So let me
8 give you a little bit of background as to why we
9 conducted this needs assessment for the state. The
10 commission is currently developing the Alaska state
11 plan for senior services, along with a statewide
12 advisory committee. This is a comprehensive
13 four-year plan that is required by the federal
14 government for all states to draw down federal funds
15 to run a variety of senior programs and services,
16 most of them being grant funded.

17 It includes home and community
18 based services, like services that are offered by
19 the senior centers, meals, rides, transportation,
20 and so forth. Also support services in
21 transportation for tribal agencies, legal
22 assistance for seniors, elder protection, adult
23 protective services. The Office of the Long Term
24 Care Ombudsman gets funding as well as media, too,
25 and for other purposes.

1 So in developing the state plan, a
2 critical component of the state plan is a needs
3 assessment. This time around, we thought we would
4 do the needs assessment in a variety of different
5 ways that included surveys as well as Elder Senior
6 Community Forums as way to gather both quantitative
7 and qualitative data.

8 So the senior survey was a
9 four-page survey. It was distributed widely to
10 senior centers and senior provider organizations.
11 It was posted on our website as well as other state
12 agency websites, and it was published in the Senior
13 Voice.

14 We received a huge response from
15 seniors. More than 3,000 seniors, people age 50
16 years and older, responded to the survey, of which
17 2,836 came from people age 60 years and older.

18 We also did a provider survey.
19 That was an online survey where we received
20 responses from 50 senior providers.

21 And then lastly we did Elder
22 Senior Forums, and we did six forums in the state
23 this last year: In Fairbanks, Anchorage, Juneau,
24 Kotzebue, Bethel, and also with the Alaska Native
25 Tribal Health Consortium Elders Committee. And we

1 had anywhere from 10 to 50 people participate in
2 these forums. That included seniors, elders,
3 family caregivers, and people who are interested in
4 senior issues.

5 So, first of all, we'll talk about
6 the findings of service gaps in the continuum of
7 care for seniors and what seniors told us. The
8 first -- the most important concern that seniors
9 have about services in Alaska is their access to
10 primary care. This was the number-one concern by
11 seniors. We had about a third of the respondents
12 identify this as their primary area of concern.

13 And most of the reasons had to do
14 with people not being able to find primary care
15 providers, doctors in their communities, either
16 because -- in most instances, they didn't accept
17 Medicare as a form of reimbursement; and secondly,
18 that there is not enough doctors in the community,
19 not enough providers. So, you know, this was a big
20 concern.

21 I just -- I also wanted to mention
22 that in the survey, we had a series of comments.
23 We had over 1,000 comments that people provided,
24 and that for this issue alone, people -- there were
25 173 comments regarding health care access for

1 seniors. And I just want to read you one quote
2 that -- and it reads like this: "My wife and I
3 will be leaving Alaska in the next year or so. I
4 was born in Alaska. My wife came to Alaska over 30
5 years ago, and she fell in love with the state.
6 But the difficulty with finding doctors who will
7 take Medicare and the high cost of living are
8 making our move from Alaska necessary. I thought
9 we would never have to leave Alaska." So that's a
10 big problem for seniors for sure.

11 We're finding that in looking at
12 the Medicare refusal issue by region that it's most
13 likely occurring in the Anchorage area, where one
14 in four seniors who responded to the survey
15 indicated they had a problem. But it's also
16 occurring in Southcentral, Fairbanks, as well as in
17 the Aleutian Islands.

18 Five years ago, in 2005, we did a
19 similar survey, and in that survey we also found
20 that access to health care was seniors' number-one
21 issue. But at that time, it was indicated by
22 24 percent of the survey respondents, where now
23 it's 31 percent; so the problem of access to care
24 is growing.

25 And it's also compounded by the

1 fact that we're having a growing shortage of health
2 care providers, because a lot of doctors and other
3 health care providers are preparing for retirement,
4 and we're not seeing the number of new providers
5 coming in to take their place and also to serve
6 this growing population of seniors.

7 Financial security was the second
8 most important issue for seniors. We found that
9 one out of five seniors who responded to the
10 survey, or about 20 percent, said that they don't
11 have enough money to meet their monthly needs.
12 They don't have enough money to buy food, pay for
13 high fuel costs. So that tracks well with the
14 percentage rate for the senior benefits program.

15 We also found that two out of five
16 seniors said that they have just about enough money
17 to make ends meet; but if there was an emergency
18 situation where they had their furnace break down
19 or they had an emergency medical situation, they
20 didn't have enough money to cover it.

21 Housing was a big concern for
22 seniors in terms of them living in homes that
23 needed rehab and accessibility, also insulation.
24 This was a big problem for people especially who
25 live in rural areas of the state, where getting

1 around is difficult and they don't have that
2 accessibility in their homes. Also just even
3 having something that, you know, as simple as ramps
4 that we take for granted in urban areas where you
5 have got concrete supporting the ramps, it's very
6 difficult to build those ramps in rural areas where
7 the homes are located on permafrost.

8 We also ask seniors about their
9 use of senior services, and we found that about a
10 third of the respondents used any senior services,
11 which means that two-thirds don't.

12 So the people who did use the
13 services had very high satisfaction levels for the
14 services they received, with the highest
15 satisfaction going to people who received adult day
16 program service as well as home-delivered meal
17 service. But everybody had a really high level of
18 satisfaction of the types of services they receive.
19 And people really appreciated the senior centers.
20 That was a focus for a lot of them.

21 MR. CAMPBELL: Question?

22 MS. DANIELLO: Yeah.

23 MR. CAMPBELL: The two-thirds that
24 aren't using them, I would ask you whether they
25 either don't need them because of their health

1 status, and et cetera, et cetera, or they are not
2 available. We heard this morning that people want
3 to stay independent as long as they can, so I would
4 presume that those two-thirds, in their own mind,
5 think -- or most of them -- don't need the services;
6 is that right? Or am I wrong?

7 MS. DANIELLO: I think that's
8 correct. In their minds. But also in some
9 communities, a lot of these services are not
10 available. As Kay mentioned, especially in rural
11 communities there is a shortage of services. But a
12 lot of seniors are pretty able-bodied and able to
13 get around, in their minds, you know, just fine.

14 And also we talked a little bit
15 earlier about the importance of family caregivers.
16 You know, I just -- even though we're seeing this
17 trend of family caregivers -- we are not seeing as
18 much of the family caregiving as we used to see,
19 say, 50 years ago because of the change in the
20 economic conditions, family caregivers are doing
21 one bang-up job of taking care of elders -- their
22 parents, their aging parents, their grandparents,
23 aging spouses, and they provide the foundation for
24 long term care. If we didn't have them, we would
25 be really in bad shape.

1 Yes?

2 MS. DAVIDSON: I've got a
3 question -- I guess more of a statement. I really
4 appreciated your mentioning the challenges of
5 providing care for an elder who lives in a rural
6 community. And people just need to know that in
7 some communities, especially a community without
8 running water, if that person can't -- doesn't have
9 someone who can help them to pack their water
10 from -- which may be a half a mile or a mile away,
11 and somebody to pack -- somebody to chop wood for
12 them, then that may be the difference between that
13 person being able to live independently and not.

14 And interestingly, there's no
15 reimbursement for that piece.

16 MS. DANIELLO: Yup.

17 MS. DAVIDSON: And rural Alaska is
18 the only part of the state that has that challenge.
19 And while you think it would be covered as a part of
20 chore services and assisting with activities for
21 daily living, there is no current recognition for
22 that service.

23 MS. DANIELLO: Yes. And that was
24 something, too, that I was going to mention, because
25 we heard that as well when we did the Elder Senior

1 Community Forums out in the rural areas. Yes.
2 Thank you.

3 MR. CAMPBELL: But my wife thinks
4 she should be paid too.

5 (Laughter.)

6 MS. DAVIDSON: I'm not going to go
7 there.

8 COL. FRIEDRICHS: We call it combat
9 pay.

10 MS. DANIELLO: So moving on to the
11 provider survey, we, again, received responses from
12 50 providers and asked them about their perceptions
13 about senior concerns as well as their perceptions
14 about services offered for seniors. And many, many
15 providers told us that they are very concerned about
16 having -- in just looking at this demographic boom
17 of the senior population and experiencing it, too,
18 they are very concerned about being able to provide
19 more services to more people, more intensive-type
20 services with a relatively same level of funding.
21 That's a big concern for providers.

22 Also workforce issues too:
23 Recruitment, training, and retention can be huge
24 barriers for many nonprofit provider organizations
25 who are receiving limited funds to pay their

1 workers. It's real hard to recruit those workers
2 to their organizations when they are competing with
3 Fred Meyer's and Safeway and, you know, some of the
4 other big stores that pay a little bit better and
5 provide benefits. So it's a challenge.

6 When we asked the providers what
7 they saw as being of concern for seniors, they saw
8 financial security as being of the highest concern.
9 And for seniors, that was a little bit below health
10 care, access to primary health care.

11 And they also saw that seniors
12 were just having a really hard time being able to
13 make ends meet. They saw more people coming to the
14 senior center for meals, able to contribute less to
15 the donation of meals, and just needing more
16 supportive services.

17 We also asked them to identify
18 what's missing in the system of services. And the
19 service that had the most response was the need for
20 seniors to have more home modification services to
21 help them live in their homes longer, and also
22 senior companion services. This is primarily for
23 people with early and mid stages of Alzheimer's
24 disease and related dementia that need queuing and
25 supervision in order to continue to live

1 independently. Also access to more affordable and
2 accessible housing, because there is not enough
3 housing around. Having enough food to eat, and
4 assisted living for the mentally ill. This is a
5 new population, an emerging population of seniors
6 that we don't have a lot of services for.

7 Okay. In this last slide, I just
8 wanted to talk a little bit about what we found out
9 when we conducted these Elder Senior Community
10 forums. This was very -- was a really good way for
11 us to gather information, because it was very
12 qualitative, and people were very expansive in what
13 they told us.

14 But, hands down, the issue that
15 was most important was access to primary care,
16 particularly for seniors who participated in the
17 Anchorage and the Fairbanks forums. We didn't hear
18 about it so much in the rural forums. We didn't
19 hear about it for people needing access to
20 specialized medicine. That's not a problem. And
21 even Medicaid pays better than Medicare.

22 Medicare, as you may know, pays
23 only about two-thirds of what a doctor can get from
24 private pay, and a doctor can get \$60 or less from
25 serving a patient on Medicare.

1 DR. LAUFER: Usually less.

2 MS. DANIELLO: Yeah. Usually less.

3 And so there are some -- there's,
4 you know, a lot of efforts to try to expand that
5 primary care access, especially in Anchorage; but
6 it's definitely a problem, and it's something that
7 needs to be addressed.

8 Also, participants across the
9 board identify their strong support for long term
10 support services. And these are primarily support
11 services offered at the home and community based
12 level in people's homes and in their communities
13 and to meet the needs of a growing senior
14 population.

15 As Kay Branch mentioned, there are
16 few services for elders who live out in the rural
17 areas. In the rural areas, the core services are
18 provided by senior grant-funded services. Those
19 are the services offered by the senior center.
20 Those are the basic services of meals and rides and
21 social supports.

22 But in terms of personal care
23 attendant services, waiver services through the
24 Older Alaskans waiver or the waiver of persons with
25 physical disabilities, not too many in rural areas.

1 Part of the problem has to do with the fact that
2 there are very few providers. It's difficult for
3 these providers to stay in business, given the
4 reimbursement rates. And as Valerie pointed out,
5 out in rural areas, if you don't have access to
6 running water or a consistent fuel supply, it makes
7 everything take a lot longer.

8 Task time is so much longer to do
9 anything, to bathe a person, than what our
10 reimbursement rates reimburse for. So where maybe
11 giving someone a bath might be 20 minutes in
12 Anchorage, Alaska, it might take an hour, you know,
13 if you were living in Bethel or in Togiak, Alaska,
14 where you don't have access to running water all
15 the time. So everything is much more complicated.

16 In terms of senior housing, again
17 people just identified the need for more senior
18 housing, especially accessible, affordable senior
19 housing, senior housing that is also for people who
20 in the middle income range. We have senior
21 housing, congregate senior housing for people who
22 meet the lower income threshold, but there is also
23 a need for senior housing for people who are in the
24 moderate income levels. Also, senior housing that
25 has supportive services on site too -- that's

1 another important gap in our services here.

2 Seniors with complex behavioral
3 health needs -- this is a big need that's growing
4 in our state of people with advanced dementia who
5 also have a co-occurring chronic mental health
6 disorder. There are very few licensed assisted
7 living facilities in our state that can care for
8 this population of seniors.

9 This week I did a count of how
10 many assisted living facilities we have in our
11 state. There are 20 that are duly licensed to care
12 for people with dementia and chronic mental
13 illness, but they are also licensed to provide
14 service to people with developmental disabilities
15 and chronic mental illness.

16 There are no facilities that I'm
17 aware of in the state that just focus on seniors
18 with dementia and chronic mental illness. The
19 Pioneer Homes are not licensed to serve this
20 population, and a lot of times people get
21 transferred over to API, Alaska Psychiatric
22 Institute, but that's not a permanent place for
23 them either. So this is something that we need to
24 focus on in terms of building our long term care
25 support system.

1 Transportation was a huge need
2 identified by everybody in the forums. It's not
3 only seen as a barrier for people getting access to
4 medical appointments, but also for maintaining
5 a life in the community, of being able to go to
6 work, being able to go to their volunteer
7 placement, going to the movies with a friend, go to
8 the beauty shop. So transportation is really
9 important for breaking that sense of isolation and
10 for making sure that people stay connected to their
11 community.

12 Yes?

13 COL. FRIEDRICHS: Thank you for an
14 excellent presentation, and this is a helpful list
15 of things that people identified in the community.

16 So our charter, as a commission,
17 is to look at how to improve access, how to improve
18 quality, and control costs. Have you been able to
19 prioritize this to help us understand which of
20 these would have the greatest impact on improving
21 quality and access and controlling costs?

22 MS. DANIELLO: Well, I can say
23 this. We haven't gone through all -- this list of
24 services, but in terms of what seniors identified
25 for themselves, access to primary health care is

1 really important for them, and then also the
2 reliance and the support for home and community
3 based long term support services.

4 So having those services being
5 provided in one's community and in one's home is
6 what people want. And it also saves money, big
7 time, for the state, for everyone.

8 Did you have something?

9 DR. LAUFER: I do have a question:
10 Do you have any suggestion as to how to improve
11 access to primary care? You know, I feel this. We
12 see almost 5,000 people a year. They are never
13 simple. The acuity of these patients is going
14 through the ceiling. I'm not an internist. There
15 hasn't been a new internist in Anchorage for a
16 while.

17 And what I'm rewarded with is flak
18 from the people I do see that I don't see more and
19 bad press about how we're greedy and really an
20 absolute lack of recognition for what is actually
21 charitable giving. All Medicare medicine is
22 nonprofit. We pay for the privilege to do it. I
23 lose about \$105 personally every time I see a
24 Medicare patient.

25 MS. DANIELLO: Thank you for that.

1 I think you articulated those concerns well.

2 DR. LAUFER: What do we do?

3 MS. DANIELLO: Well, I know, at the
4 legislative level, Representative Keller could also
5 probably talk about this too. There are a couple of
6 bills that are aimed at trying to do something about
7 this access-to-care issue for seniors. One of them
8 is HB 78, I believe, by --

9 REPRESENTATIVE KELLER: Herron.

10 MS. DANIELLO: -- Representative
11 Herron. I just testified on that bill yesterday.
12 You'd think I'd know it. And that is to provide a
13 loan payment incentive and employee incentive
14 program to help with recruitment of more health care
15 providers to our state. This would be new health
16 care providers, but also experienced ones.

17 And then also there is Senate
18 Bill 87, I believe, sponsored by Senator French,
19 that provides a grant supplement to providers who
20 are serving people in medically underserved
21 communities, focusing on seniors age 65 and older
22 who are on Medicare, and also in communities where
23 seniors are not being -- are having a problem with
24 access to care. So that would be a grant-funded
25 program, a grant supplement to those providers.

1 DR. LAUFER: Like I said, this is
2 being done at great cost.

3 MS. DANIELLO: Yes.

4 DR. LAUFER: The majority of
5 clinics are moving away. Nationally, more than half
6 of primary care docs will not take Medicare. It's
7 not -- you know, we'd like to pretend that health
8 care is somehow moved by market forces. Well,
9 perhaps, but it's a lot more complex.

10 No one is competing for these
11 patients. You could have, you know, thousands of
12 primary care docs and maybe have some people who, I
13 don't know, had inherited a lot of money and wanted
14 to do something with their time. But no business
15 is competing for their business. You lose money on
16 them. I mean, I don't -- it's expensive to be old
17 and frail.

18 MS. DANIELLO: Yes, it is. It is.

19 DR. LAUFER: And we have to decide
20 to pay for it.

21 MS. DANIELLO: And the other thing
22 is that, you know, people don't recover from being
23 old and frail.

24 DR. LAUFER: No. If you do a great
25 job, they get frailer and older.

1 MS. DANIELLO: Yeah. Yeah.

2 DR. LAUFER: And more -- maybe.

3 MS. DANIELLO: Yes. Yes. And

4 Duane's nudging me to move off the seat.

5 COL. FRIEDRICHS: But I think
6 perhaps Noah and I are asking the same question
7 here, although he's, as usual, more eloquent than I
8 am.

9 You've shown very nicely across
10 your various presentations an excellent problem
11 statement. We have -- you know, the number of
12 elderly will double. We know, from other
13 presentations, the number of workers who will
14 generate income will decrease over that time.
15 Unless something miraculously happens in the energy
16 industry to increase revenues, we'll have to, as I
17 understand it, keep doing more of the same, perhaps
18 double or more of what we're doing today to
19 maintain a status quo or perhaps provide fewer
20 services.

21 My question to you all was
22 absolutely not meant as a facetious question
23 earlier. Are there any best practices? Are there
24 any innovative ideas? Are there any suggestions
25 from you as the experts on this for how to improve

1 access, control costs, and improve the quality of
2 what we're doing?

3 I mean, for us to come back as a
4 commission and say, "Wes, plan on spending twice as
5 much over the next 15 years" is the easy answer.
6 It is neither sustainable nor plausible. And so
7 our challenge is -- we've got the problem
8 statement. Beautiful. And I commend you, because
9 you've done a very nice job of coming out with what
10 the elders are experiencing here. I think all of
11 your presentations have been superb from that
12 standpoint.

13 The so-what question is: Where
14 are the opportunities to do something different,
15 something better beyond just plan on spending twice
16 as much money?

17 MS. DANIELLO: Yes. And I think
18 that's all excellent points and a well-taken
19 question. I just want to -- you know, I'll give you
20 my opinion, but I want you to know that there is a
21 whole group here that has a lot of experience and
22 knowledge in this area.

23 But personally, I think that we
24 need to become more strategic in the way we think
25 about providing long term care services and how

1 we're going to pay for them. In our state, as well
2 as nationally, Medicaid is the big payer for long
3 term care, but we need to start thinking outside of
4 that box in terms of, you know, what other funding
5 sources can we bring in.

6 We're having now health care
7 reform, and there was passage of provisions from
8 the CLASS Act that talks about long term care
9 insurance. That's one possible way. The states'
10 retirement insurance, that might be another
11 possible source. Right now, I'm not sure how well
12 the states -- and this is something that we're
13 going to be looking at in the future -- how well
14 the state's retirement insurance is paying for home
15 and community based services. There is also a VA
16 program, too, that's coming out in support of long
17 term care support services.

18 CHAIRMAN HURLBURT: I just want to
19 make maybe a process comment, because we're not
20 through our presentations yet, and I'll help Duane
21 nudge, I guess. But -- we appreciate your
22 graciousness in responding, but I think we have one
23 more presentation.

24 MS. DANIELLO: Yes, we do.

25 CHAIRMAN HURLBURT: And then, if we

1 can take the rest of time after that, between then
2 and 10:00, to ask questions of the panel, then
3 basically the next half hour will be a discussion
4 among the commission members about the information
5 that's been presented about what we feel we should
6 do as we go on. So maybe if we could move on with
7 the other one.

8 But, Denise, thank you very much.

9 MS. DANIELLO: Yes. Thank you.

10 And you have the other needs, too, there on the
11 slide.

12 Thank you, everyone.

13 MR. MAYES: I'm going to respond in
14 terms of where do we go from here, but I would like
15 to invite Nancy Burke, from the Alaska Mental Health
16 Trust, to come up here.

17 But before she gets started, you
18 know, I was going to save this till the very end,
19 but I think, given some of the questions that have
20 been asked, at least we can put this out right now.

21 So what does this all mean? We've
22 given this presentation, and where do we go from
23 here? And one of the last slides has to do with
24 the future, future activities.

25 And so this group will come

1 together over the next 12 months on a regular basis
2 to look at all of the past analyses that have been
3 done on long term care. We brought a bag, and,
4 Denise, if you could just hold that up. It weighs
5 like about 200 pounds.

6 MS. DANIELLO: Actually, this is
7 not the complete bag. This bag contains some of the
8 reports and studies about long term care that have
9 been done over the last 20 years. I like to collect
10 these. Some people, they collect coins. I like to
11 collect long term care plans.

12 MR. MAYES: It's her hobby.

13 MS. DANIELLO: There's about 20 of
14 them.

15 MR. MAYES: But the more recent one
16 was done back in 2008 from Home and Community Based
17 Service Strategies Inc., and so that's the most
18 current one that I can think of. Maybe Nancy might
19 know of another one that was done.

20 But we will look at this. The
21 Trust will play a role in it in terms of being a
22 partner if we need some type of financial
23 assistance to hire a contractor to really drill
24 down in all of these different analyses that have
25 been done. But the goal would be that in May of

1 2012 -- that's the goal -- is to come up with some
2 recommendations.

3 And I understand that, you know,
4 we're concerned about the health, welfare, and
5 safety of Alaskans; our vulnerable population,
6 seniors, people with disabilities. And we
7 understand that cost containment is front and
8 center, but what's important is that we come up
9 with addressing that issue of health and safety and
10 wellness.

11 MS. BURKE: Thank you. Again, I'm
12 Nancy Burke. I'm a program officer with the Alaska
13 Mental Health Trust Authority, working with our long
14 term care services and the housing programs. And
15 we've been investing in housing for the past five
16 years, recognizing that, as you've highlighted very
17 well, the access to health care and the social
18 service programs intersect very nicely in a number
19 of different realms.

20 And one partner that has come up
21 recently in Denise's presentation is that of our
22 housing industry. It's an economic resource in the
23 state that is both scarce and has huge potential
24 for us. It's a piece of the conversation. It
25 certainly doesn't address the big questions that

1 you were just asking about: How can we afford care
2 for people through Medicare? But we've had some
3 pretty amazing things come out of the housing focus
4 area, so I'd like to just review those for you.

5 The supported housing stock in
6 Sandra's presentation -- what was not highlighted
7 was the fact that many of the social service
8 providers on that list actually own and operate
9 housing. And we've had some problems in recent
10 years with some shifts in how the funding
11 mechanisms happen, and those social service
12 agencies have struggled with maintaining those
13 housing units and the costs that are associated
14 with it; especially as you hit your 20- and 30-year
15 marks of owning housing, as we all know from our
16 own homes, that you come into roofs that need
17 replaced, you come into sidewalks that are
18 crumbling, some pretty major deferred maintenance
19 work that needs to happen. And it can be
20 crippling.

21 In fact, in Fairbanks we saw that
22 the housing stock nearly took down an agency,
23 because the costs all arose at the same time there
24 were workforce issues, and it was sort of the
25 perfect storm. But it highlighted for us the fact

1 that housing can be the backbone for our long term
2 care services, and housing does address some of the
3 concerns that were raised earlier.

4 So we've done some major technical
5 assistance and assessment across the state, and
6 we've highlighted some areas where we've worked
7 with partners like Alaska Housing Finance
8 Corporation and the department to better support
9 the state's financing of housing.

10 And that's important for health
11 care and social service providers, because other
12 states have used their housing engine as a way to
13 provide some flexible spending, some flexible
14 grants in the financing of those programs, which
15 allow for transportation and consistent follow-up
16 with health care needs of the residents of those
17 programs.

18 And as many of you who are
19 providers know, it's important that people maintain
20 their regular contact with their providers and that
21 they follow through on recommendations. And when
22 that doesn't happen consistently, we see people
23 bubbling up more into emergency levels of services.

24 And so 35 other states have used a
25 mechanism described as a housing trust, which means

1 that as they develop housing for people who require
2 support services, they add in extra resources that
3 allow them to adequately address their needs.

4 And so that's what Alaska has
5 implemented. We've seen programs coming on line.
6 We're replicating programs that are happening out
7 of state through our Special Needs Housing Grant
8 program, and I think I'd like to share with you
9 some of the outcomes of what other states have
10 seen.

11 In Seattle -- I'll start
12 locally -- Seattle implemented a housing program
13 for just four individuals, and they tracked them
14 for over two years. I think I'm off the slide. I
15 have to apologize. I just got off the plane
16 yesterday from an extended vacation, so I'm
17 probably somewhere over some other time zone right
18 now. So I'm just going to talk through this part,
19 and then I'll come back and see if you have
20 questions. I'm on the second bullet down here.

21 Programs in Seattle and Anchorage
22 and Sitka have demonstrated health outcomes for
23 residents. In Sitka, they tracked four people over
24 two six-month periods, one before the program
25 opened and one after the program opened. For air

1 ambulance in Sitka, they had two people removed
2 from the community on an air ambulance during the
3 six months prior. They had 89 non-ICU days six
4 months prior, 27 ICU days, 47 Title 47 holds, and
5 one medical EMS call.

6 They implemented a housing program
7 that provided on-site staff that assisted people in
8 maintaining daily activities, accessing their care
9 providers, addressing some alcohol and addiction
10 needs. And six months after they implemented this
11 program, they had no air ambulance, they had 8
12 non-ICU days, zero ICU days, 8 Title 47 holds, and
13 4 medical EMS calls. So you see that the medical
14 calls went up because somebody was monitoring their
15 needs, and those calls were made appropriately.

16 The cost estimated for Sitka of
17 this program prior to implementing it was \$150,000.
18 The cost after the program for these four
19 individuals went down to \$15,000. So you can see
20 the magnitude. You know, that's Sitka, but for
21 that community, that's a lot of money in their
22 budget. And they estimate that, over time, this
23 program, with just four individuals, saved the
24 community \$400,000. That's police, that's pickup,
25 that's hospital services, air ambulance. It's a

1 community perspective, but you can see the impact
2 that that has for Sitka.

3 In Seattle, a larger scale program
4 looked at 95 people who were housed and 35 people
5 on a wait list. And you can see this study in the
6 JAMA, the Journal of the American Medical
7 Association, March 2009.

8 They estimate that the cost of
9 participants before the study was about \$8,175,922,
10 with a median cost per person of about \$4,066 six
11 months prior to the program. After they
12 implemented the program, they saw those costs go
13 down to about \$1,042 per person at the six-month
14 mark, and then down to \$958 at the 12-month mark.

15 They think that this program, in
16 their first year of service, saved the county
17 hospital -- primarily the county hospital and the
18 city about \$4 million, which they were able to
19 allow police officers to go back to doing what they
20 do, EMS to go back to doing what they do. Not all
21 of that was actually savings in their pocket, but
22 the services were not needed by people. They
23 weren't consuming the services at the same rate.

24 So you can see that housing -- and
25 it's somewhat intuitive for us, that if a person is

1 housed and stable and has support services, I guess
2 my answer to the question that came previously was,
3 you know, the costs that are driving up, we found
4 in Medicaid programs that targeted case management
5 and in other programs, that having that on-site
6 person or someone in regular communication reduces
7 costs by allowing the person someone else to think
8 decisions through and to know when to pursue
9 additional treatment and when not to, and to also
10 make sure that follow-through on chronic conditions
11 is happening. They have seen some pretty amazing
12 results with diabetes with targeted case
13 management.

14 The other thing I would add to it
15 is that we, in Alaska, are really leaders in the
16 state. I maybe heard some apologetic language from
17 my colleagues about our social service system, and
18 it's highly regulated. It's a professional
19 workforce. A number of people, myself and a number
20 of colleagues, have worked our way through this
21 career ladder. I started on the lines in a
22 developmental disability program. It's a
23 tremendous resource and engine for the state. And
24 the workforce capacity in this area really should
25 be viewed as an asset for us. So I'll put that

1 little plug in.

2 Just one other thing I wanted to
3 highlight for you, which is not on your slides.
4 But some of the things that are also driving the
5 cost of care for people in this state is just
6 economics and what's happening. I'll just
7 highlight a couple of communities, but I have the
8 cost of what it takes to rent a two-bedroom
9 apartment. In 2000, in Juneau, since we are here,
10 it was \$1,100, and in 2010 it's \$1,281 to rent a
11 two-bedroom apartment.

12 So you can imagine that a
13 family -- or if an elder isn't in the position of
14 owning their own home but needing to move closer to
15 services or to be near family, renting a unit in
16 this state is a considerable cost. In Bethel, the
17 cost for a two-bedroom in 2010 is \$1,418. It's
18 \$1,031 in Anchorage, \$1,124 in Ketchikan. It takes
19 a considerable amount of resources to be able to
20 even rent a unit.

21 So you see that people who maybe
22 become more transient or who become homeless, we do
23 see additional resources going to emergency
24 services for them, because they just don't have the
25 resources. They don't have that home base, the

1 stability to pursue care at a lower level and at a
2 lower cost.

3 So for the Mental Health Trust
4 Authority, we're pursuing housing as one of the
5 primary cost reduction strategies for a number of
6 our programs. And we'd like you to consider that
7 as you deliberate.

8 Thank you.

9 MR. MAYES: Okay. So that is our
10 presentation, and I'd like to open it up for
11 questions. You have seven of us here, and I do want
12 to add that Joanne Gibbens, who is our Deputy
13 Director for the Division of Senior & Disability
14 Services is here, she keeps me out of trouble. So
15 she's back there.

16 So questions.

17 REPRESENTATIVE KELLER: Before
18 Nancy gets too far away.

19 MR. MAYES: And this will be an
20 exercise of back and forth to the mike.

21 REPRESENTATIVE KELLER: I want to
22 make what I see as an explanation, but I would like
23 you to keep me really straight. Okay?

24 MS. BURKE: Okay.

25 REPRESENTATIVE KELLER: The Trust

1 has money to invest; and what happens is, an area of
2 need is identified, like the housing need for long
3 term care. The trust money, assets get invested in
4 expanding the access to, in this case, housing for
5 long term care, and they do an excellent job at it.
6 And they are right up front with this, by the way.
7 But what they do is it's designed in such a way that
8 ultimately the cost of the program comes back to the
9 general fund budget. Ultimately, that's the way
10 it's set up, whatever isn't picked up by other
11 sources.

12 And the savings, from a
13 legislative perspective, we have to take on faith,
14 because we don't see the budget where this year
15 it's going to cost less because of the investment
16 that had been made. So what has happened is, the
17 investment gets made. The access and the quality
18 improve, and it's very good, you know, I mean, what
19 happens for the people that are in need. But from
20 a legislative perspective, we really struggle,
21 because all we see, again, is a continuing
22 escalation of the cost.

23 So I wanted to put that on the
24 record, and the trust does not hide this. I mean,
25 this is on the record. You can all check it out.

1 them, the tendency is to look more and more and more
2 to the provisions that are made. That's what I
3 worry about.

4 MS. BURKE: Thank you.

5 MR. MAYES: Other questions?

6 COL. FRIEDRICHS: Thank you very
7 much, Representative Keller, for that clarification.

8 Again, going back to the question
9 that I was asking -- and, I think, Noah, you were
10 getting to also: The challenge, at least for me,
11 has been we've heard from a variety of people from
12 a variety of parts of the health care industry
13 coming forward and saying, "We have great programs.
14 Our programs make a difference. We really believe
15 in our programs. And here's all the problems: The
16 population of elders is doubling. The federal
17 reimbursement is decreasing. We can't attract
18 enough primary care providers." And that's been a
19 very consistent message across multiple
20 presentations here.

21 The challenge for us is to move
22 beyond those problem statements, though, and make
23 recommendations. And it's heartening to hear that
24 you all are going to look at this and have a report
25 back in May of 2012. We are required to provide a

1 report in January of 2012. Is there anything that
2 you wish to leave with the commission right now
3 that speaks to data-driven opportunities that would
4 be defensible before the Legislature and
5 understandable, that would improve access and
6 quality, and help to control costs?

7 MR. MAYES: Good question. Anybody
8 here want to take a shot at that?

9 MS. BRANCH: I will. Hi. Thank
10 you.

11 The one thing that I would mention
12 that actually could do all three is stronger work
13 with the tribal health organizations in order to
14 provide these services, because that would also
15 save costs at the state level for state general
16 fund Medicaid.

17 And the tribal health -- I mean,
18 some of the difficulties that tribal health
19 providers have had, you know, with the personal
20 care regulations is that they prefer the
21 agency-based model, which actually has a few more
22 checks and balances; and because they're worried
23 about the quality of care, and especially the
24 quality of care that is provided by people in very
25 remote locations that can't run back to a

1 supervisory nurse that's in the same community and
2 ask a question. And so we are very concerned about
3 the quality of care.

4 So that would be one option that
5 could be on the table right away.

6 MR. MAYES: Other panelists?

7 MS. BURKE: I know this is probably
8 not a very helpful comment, but I think that, like
9 states are looking at their bridges and their roads,
10 there is an infrastructure question here in Alaska.
11 And the types of people who were drawn to the state
12 in the '80s, when I moved here, are not staying.
13 We're not competitive. We are struggling, and I
14 feel it's a downward spiral.

15 And if we don't make an investment
16 in the workforce and in our infrastructure in the
17 state, we are just going to continue to struggle
18 with higher emergency-level services.

19 And so I understand this gets us
20 into questions about revenue and how we're going to
21 do it, but getting back to the same thing that's
22 been said for many years in the Legislature, is the
23 state needs a plan. We need to fund the
24 infrastructure of our state. We need to regard
25 this as an engine and an economic resource for our

1 people and make the investment.

2 MR. MAYES: We have one more
3 response, maybe more.

4 MR. COTE: To try to respond to
5 that, I would say don't cut home and community based
6 services. You know, in all of this, trying to save
7 money in the Medicaid budget that is spiraling out
8 of control, it's kind of like a balloon. If you
9 take from somewhere, it's going to push out
10 somewhere else. And the danger in that is it might
11 bulge into, as Sandra has said, higher-cost nursing
12 home and hospital services. So consider that.

13 Thank you.

14 MR. MAYES: And you had asked a
15 figure of what PCA services cost on an annual basis,
16 and I mentioned about \$24,000 -- of the waivers that
17 we have through the Division of Senior & Disability
18 Services, and Sandra spoke to the four waivers. The
19 average cost is around \$41,000 a year for the four
20 waivers. And remember, waivers are optional.
21 Institutional nursing home level of care is around
22 \$86,000.

23 MS. DANIELLO: Actually, it's
24 higher than that.

25 MR. MAYES: It's higher now.

1 MS. DANIELLO: It's over \$200,000.

2 MR. MAYES: Oh, is that right?

3 Okay. I stand corrected. Significantly.

4 Any other questions?

5 MR. MORGAN: Yes. It's back to
6 waivers. If you break waivers down to the four,
7 that three of the waivers are absolutely cost
8 effective. One, the fourth one, is cost effective,
9 but a lot -- you know, when you average costs, it
10 kind of skews that a little bit. It would be nice
11 to see the four waivers broken down -- for me,
12 anyway.

13 I just personally know -- I work
14 with a program that does three of them over the
15 last couple of years; but I know that still, on the
16 average, they are cost effective. I have never
17 heard anyone say they weren't. I just know that
18 the four of them do have differences in them in
19 what they cost per person per year.

20 Thank you.

21 MR. MAYES: That's correct.

22 MS. DANIELLO: And I just want to
23 build on your comment that also part of the long
24 term care continuum are these support services that
25 are funded by grants. Now, grants are really

1 important, because they provide prevention and early
2 intervention. So they prevent somebody from
3 becoming Medicaid eligible. They help to do that.
4 They help to make sure that that person has a ride
5 to the doctor; that they are eating, you know, at
6 least one good meal a day; that their family
7 caregivers are getting some respite, which is really
8 important.

9 So, you know, in terms of from the
10 senior grants point of view, it's about, I think,
11 \$800-some dollars a year, I think is the average
12 grant amount for a person who utilizes those
13 services. So that's really cheap. \$800 or so a
14 year versus \$200,000.

15 So that's -- when we were talking
16 about, you know, looking at other sources of
17 funding and being more smart, more strategic in the
18 way we look at long term care and how to pay for
19 it, investment in home and community based services
20 is really important. And supporting the family
21 caregiver -- if the family caregiver isn't there to
22 do their job in providing the long term support
23 services in the home, and they get burned out --
24 and this is a real problem for families who are
25 caring for people with dementia, because that's

1 very trying. Then people get admitted into the
2 nursing home at a much -- at an earlier stage, and
3 they are there longer. And we all know who pays
4 for that.

5 MS. ENNIS: Denise, I can certainly
6 speak to the care by families in terms of most
7 families resist asking for help until they really
8 need it. It's usually when they are almost to the
9 breaking point and can no longer continue to provide
10 services.

11 And I think we really don't have
12 clear data on how many families in Alaska are
13 providing this extended care to their loved ones in
14 their home. It's so important that we do extend
15 that support for family caregivers through the
16 services you've talked about.

17 I had heard that once a family
18 decides to use care and calls on a provider, that
19 generally the care that then is provided is perhaps
20 no more than two years, one to two years of care,
21 before they finally ask. So the notion that
22 because we're growing more services and they are
23 available, that families are going to relinquish
24 that care earlier on is one that, so far, has not
25 been proven.

1 But I wondered if you could talk
2 to that average time. Do you have some more
3 current data as to what is the average use of those
4 services once a family asks for them?

5 CHAIRMAN HURLBURT: Maybe if you
6 could do it in one minute, and then we do need to
7 move on.

8 MS. DANIELLO: I don't have that
9 data; but just to mention that there was a study
10 that was done by a New York university that looked
11 at how long the delay in nursing home placement was
12 for family caregivers who were provided with
13 extended respite and counseling support, it was 2.4
14 years.

15 MS. ENNIS: Thank you.

16 CHAIRMAN HURLBURT: Thank you.

17 Duane, thank you very much, and
18 thank you for the whole group. That was an
19 absolutely outstanding tour de force of the field
20 for us.

21 (Applause.)

22 CHAIRMAN HURLBURT: And we
23 appreciate all of you coming. We appreciate your
24 preparation, and we appreciate your work on that.

25 Rich, if you could put up that

1 slide again there.

2
3 LONG TERM CARE IN ALASKA
4 COMMISSION DISCUSSION
5

6 CHAIRMAN HURLBURT: What we need to
7 do now -- the request that came really from Sandra
8 and from Delisa was for the Health Care Commission
9 to look at this whole area of long term care and,
10 first, to make a decision: Should this be a part of
11 our purview? What is health care? What is within
12 that?

13 And I think we tend, in the United
14 States, to be fairly embracing and to include a lot
15 of things that others may not necessarily include.
16 In talking about the Indian health program, it was
17 mentioned that it wasn't that long ago that long
18 term care was not a part of the benefits. It was a
19 problem. It was a challenge for you, but that was
20 not a part of the benefits, not a part of what was
21 done. But that doesn't mean the need wasn't there.

22 As a surgeon, it's older folks --
23 and we've talked mostly about older folks today --
24 are those who get the cancers. But if I resected
25 their colon for a colon cancer, the safety valve

1 was sending them to Bethel or Dillingham or Barrow
2 if they needed to have somebody pack their wood or
3 pack their water, or they didn't have the resources
4 at home. And so that impacts length of stay in the
5 acute hospital.

6 So it impacts health, but what is
7 health? Because we have had some fairly
8 broad-ranging things.

9 This embraces the waiver and the
10 personal care attendants, the top two lines with
11 the projections there, that's just going to
12 overwhelm everything else. That's part of why
13 we're talking about it. But Mark also had a slide
14 yesterday that showed, on our left side as an
15 audience, the things that clearly are in health
16 care. And then others -- are they, or aren't they?
17 And I believe those were not in most of the
18 information that Mark had. But that's an issue.

19 We talked about housing. Housing
20 is a real need, but is the Health Care Commission
21 the place to talk about that and deal with that?
22 And I think that's probably the first decision that
23 we need to make. Should this whole area, where the
24 need is absolutely there, where there is the
25 growing senior population, where -- I guess the

1 first time I failed retirement, I went to work for
2 a company called PacifiCare, where about half of
3 our enrollees were commercial age and half were
4 secure horizons or seniors. But when I went to the
5 hospital, three-quarters of our beds were filled
6 with seniors. Those are the folks that get in the
7 hospital. And their whole life impacts on that, so
8 it is a real issue there.

9 But I would toss that out. I
10 think that should be one of the end points that we
11 come to over these next 20 minutes now. Is this
12 something that we should take on, and should we put
13 any limits around it?

14 I would suggest my bias would be
15 we probably can't resolve the housing issues of
16 \$1,200 a month for a two-bedroom apartment, but
17 there are -- but that impacts on health. And if
18 you are spending that much for that, then maybe you
19 can't buy your anti-hypertensive medication.

20 So I think Noah has got something
21 to start off with.

22 DR. LAUFER: I'm sorry, but I'm
23 delighted that we keep coming back around to this
24 because, as I was talking to Mark yesterday, it's a
25 complex system.

1 You know, I'm young enough to
2 think when you say, "Oh, it costs \$1,200 a month to
3 rent that place," I think, well, I'm paying that to
4 a boomer. There's an 85 percent chance that is
5 owned by somebody who, in two years, is going to be
6 on Medicare and Social Security and collecting it,
7 and part of a smaller group of people who is paying
8 for it. You know, so it's one of those things.

9 What I would love -- we can't
10 define all of health care. The countries that do
11 include everything in health care, like
12 Scandinavia, have excellent health care, fewer
13 hospitals, lower costs, and a higher standard of
14 living than we do. But I would love, love, love to
15 get somebody who is an expert in complex system to
16 come and just give us a primer on this.

17 Every single thing affects
18 everybody else, and that's the whole problem. So
19 that's why you come to this idea. You know, are
20 you healthy as you define it? Are you happy in the
21 narrative of your life? And I would argue an
22 excellent political campaign, platform -- perhaps
23 not in Alaska, because it sounds like socialism --
24 but the success of the government is ultimately
25 measured in the health and welfare of its people.

1 And that can be free market. That
2 can be defense. That can be anything. But that's
3 the ultimate measure. And if that's what your
4 focus is, if that's how you measure how the balloon
5 performs, how could you lose?

6 MS. ERICKSON: Pat had his hand up.

7 CHAIRMAN HURLBURT: Pat?

8 MR. BRANCO: Just to continue on
9 with that thought, too, and from our definitional
10 discussions yesterday when we were defining health,
11 we began to broaden that definition to just -- to
12 being beyond just the absence of disease or
13 infirmity. We added the lifestyle elements.

14 On the health care side, we're all
15 well aware of the old statistic that 85 percent of
16 health care expenditures occur in the last two
17 years of life. Hopefully, those are when we are in
18 our 80s or 90s. Unfortunately, sometimes they
19 occur in our 30s. But for the most part, they are
20 occurring -- the health care expenditures are
21 there.

22 And I think that's a strong
23 argument for us to include this into our scope of
24 work, especially as we address costs.

25 COL. FRIEDRICH: I'm with some

1 reluctance, in uniform, quivering at the thought of
2 saying that I agree that we're socialists, but I
3 think I do, actually.

4 DR. LAUFER: I'm not a socialist;
5 I'm a libertarian.

6 COL. FRIEDRICHS: There you go.
7 I'm none of the above. I'm in uniform.

8 I absolutely agree, Pat, with your
9 comments about the inclusive nature. And I would
10 like to publicly thank the speaker earlier who
11 called on us collectively to have a plan.

12 Dr. Laufer often talks about the
13 narrative of health, the narrative of life.
14 Certainly from the federal standpoint, what we
15 continue to struggle with, as I shared with the
16 commission yesterday, is the concept that we can
17 put a large number of people in a state in which
18 the cost of caring for those people is \$1 per
19 person, or we can put them in Alaska where the
20 exact same care and support is \$1.75. That's a
21 real factor in decisions, long term, strategically,
22 about where we can afford to continue to station
23 people.

24 And I would challenge each of us,
25 as we look at this, to be cognizant that how that

1 relates to health care specifically goes back to
2 the whole concept of: What does Alaska want to be?
3 Health care is becoming such a huge part of the
4 budget for the state.

5 I would challenge the folks who
6 spoke today -- we didn't get into this
7 specifically, but one of the areas that we
8 identified in our report is health information
9 infrastructure, not just the technology but the
10 many tools that are out there. As our colleagues
11 from the Indian Health Service have partnered with
12 us on the federal side, we have deployed a variety
13 of tools in rural and smaller military communities
14 that have helped us to minimize the need to hire
15 yet another person or to build yet another
16 building.

17 Are there similar programs that
18 you are familiar with that we could embrace or
19 recommend embracing? And as you look at your
20 report for May of 2012, I would ask you to
21 specifically comment on that, since that's one of
22 the things that we'll be commenting on, or at least
23 encourage you to comment on that.

24 Lastly, we've touched on quality a
25 little bit in your comments and how to improve

1 quality; and several of you, I think, were very
2 kind in providing some data on the quality of care
3 which Alaskans receive in the long term system.

4 I would challenge you again, and
5 certainly from the federal perspective, what we're
6 interested in is understanding, if we're going to
7 spend this amount of money and people wind up
8 coming to Alaska and staying here, are they going
9 to receive high-quality care? Not as we define it
10 anecdotally, saying, "Well, of course it's good."
11 I mean, that's my answer at my hospital: "Of
12 course it's good care. It's my hospital."

13 But do we have objective evidence
14 to say that for every dollar that we're spending,
15 truly we're getting great value relative to
16 benchmarks around the country? And if we spent the
17 next dollar, we would get better value, based on
18 evidence, based on data, based on something more
19 than strongly held opinions or surveys.

20 And that's the biggest challenge
21 that I think we've struggled with on the federal
22 side, is how to move beyond many of the strongly
23 held beliefs. Like Noah, I did my training --
24 well, I think I did mine in the '80s. You did
25 yours in the '90s -- but there are a whole lot of

1 things that we were taught in medicine are absolute
2 truths that are now in the dustbin of history.
3 They are completely untrue, and we spent an
4 enormous amount of money on things that proved to
5 be completely wrong.

6 Where are those opportunities in
7 long term care today? Where are the opportunities
8 to challenge what we're doing and come back and
9 say, "You know what? There really is a better way
10 that would improve access, cost, and quality if we
11 adopted something that's different than what we're
12 doing"?

13 Thank you, Mr. Chair.

14 CHAIRMAN HURLBURT: Pat?

15 MR. BRANCO: I'd like to do some
16 follow-up along that, too, and your earlier question
17 when the panelists were up here too. I think these
18 are fundamental questions, and I do have quite a bit
19 of experience in both worlds. As my representation
20 would state, the Alaska State Hospital and Nursing
21 Home Association brings that to the forefront.

22 I think we got answers in the
23 presentation, but they may not have been entirely
24 evident, though. So let me just highlight for a
25 moment. One slide that was up there was the

1 continuum of care. That slide is also a perfect
2 illustration of the continuum of cost. Home based
3 service also are the least costly. Hospitals are
4 the most costly, and by logarithmic proportions.
5 So the more dollars invested per person at that far
6 left of continuum should diminish the 10-fold,
7 20-fold, 100-fold dollar cost at the end of that
8 continuum.

9 One of the key pieces to making
10 that work for us, though, is to have each element
11 along that path working to license. It's one of my
12 favorites phrases. Work to the maximum of your
13 license -- it's the most cost-effective approach --
14 before you elevate to the next higher level of
15 cost. So I think this helps us address in our
16 charter what we can do to impact this whole piece.

17 And one more piece -- and Millie
18 hit it in a very, very short period of time. It
19 has been surprising, the fundamental change that
20 occurred in long term care in particular. People
21 going home more often than they're -- I think the
22 word was "expired." I don't like expiration dates
23 on people, but it's one of many words. People
24 going home -- that profound change in just five
25 years. We've shifted that quality piece to provide

1 shorter lengths of stay in the most expensive or
2 the second-most expensive environment. This is a
3 real opportunity for this commission to have impact
4 on state Medicaid costs and really drive that
5 factor down.

6 CHAIRMAN HURLBURT: So maybe, Dave,
7 before we get to you, am I basically hearing a
8 motion that the Health Care Commission include in
9 our charge the health care -- since that is our
10 name -- health care related aspects of long term
11 care? Exactly what that is remains to be defined.
12 I'm not trying to define it, but I'm trying to limit
13 it to not having everything to do with seniors.

14 MR. BRANCO: Yes. I was advocating
15 that position, and I would make that motion now.

16 DR. LAUFER: Second.

17 CHAIRMAN HURLBURT: There's a
18 second. Any discussion before, just to be formal,
19 we have a vote on that?

20 Paul?

21 COL. FRIEDRICHS: Are you asking
22 who is in favor?

23 CHAIRMAN HURLBURT: All in favor,
24 raise your hand. Anybody opposed? Okay. Thank
25 you.

1 Thank you, Dave. Excuse me. Go
2 ahead.

3 MR. MORGAN: This will be real
4 short. I think the first question is: Is there a
5 reason why your recommendations are in May of 2012?
6 Are you waiting for December 2011 to end?

7 MR. MAYES: I'm sorry. I was
8 having a conversation --

9 MR. MORGAN: Okay. I'll repeat the
10 question.

11 MR. MAYES: Yes. Thank you.

12 MR. MORGAN: Were you or have you
13 ever been -- oh.

14 (Laughter.)

15 MS. ERICKSON: Duane, get to the
16 mike, too.

17 MR. MORGAN: The question was:
18 What is the reason for producing a report in
19 May 2012, the timeline?

20 MR. MAYES: Well, just in terms of
21 logistics. We were thinking -- actually, at one
22 point, I thought, in terms of the volume of work
23 that we're going to need to put into this to come up
24 with a credible report with recommendations, that it
25 would take about a year and a half. And I think

1 this group revolted and said, "Absolutely not."

2 And just in terms of timelines,
3 May is prior to the beginning of the establishment
4 of the budget for the state going into the next
5 fiscal year. So we were --

6 MR. MORGAN: Will the report have
7 measures of quality in it?

8 MR. MAYES: Well, that -- I don't
9 know. I would turn to the --

10 MR. MORGAN: That's just a
11 question. I --

12 MR. MAYES: Yes, a good question.
13 We are going to have our first face-to-face
14 meeting -- in fact, I was going to talk to this
15 group before they leave -- either mid-May or the end
16 of May, and then kind of set out a schedule and kind
17 of outline what we want to -- what we'd like to see
18 go into this report. And maybe we can get back to
19 you on that piece.

20 MR. MORGAN: Okay. And, last,
21 basically the reason that Deb's eyes went big, you
22 know, was, as this thing has started, it keeps
23 getting more complex, bigger. And I was expecting
24 that because the people around the table all pretty
25 well know the minutia involved and understand it.

1 Is there any way to at least have
2 a preliminary? Because the way you gaggled -- as
3 we would say in the South -- gaggled up and were
4 talking back in the back of the room, that I think
5 the outcome of the vote and what we're doing is
6 what you were hoping for; right?

7 MR. MAYES: Correct.

8 MR. MORGAN: But, on the other
9 hand, we have a really massive deadline. We've come
10 up to some tough ones to make our reports, and we've
11 gone halfway; right? Is there any way that you
12 could have a mini version or at least a preliminary
13 version for us to have, say, in November-December?

14 I mean, I think the feeling is we
15 need to address this. We need to have it in our
16 report, but we don't have -- as you can see from
17 the list of things we are going to be discussing
18 after this, I don't think we ever really, in the
19 defense of Deb and the chair, budgeted to do any
20 special work or to hire any consultants.

21 So, like I said, we have come
22 halfway. Is there any way that you guys could,
23 when you have your little impromptu discussion, at
24 least come up with a mini version or a short
25 version, so -- because we'd love -- I think our

1 goal is to add, after looking at it and discussing
2 it -- adding that into our January report.

3 Right, guys? I mean, stop me now
4 if that's not -- okay. Okay? I mean, just think
5 about it. I'm not telling you you have to.

6 MR. MAYES: My response would be I
7 think we can do that in terms of a preliminary
8 snapshot of where we're going, give you some
9 preliminary information. But I had a bunch of hands
10 over here on my right come up.

11 CHAIRMAN HURLBURT: Keith?

12 MR. CAMPBELL: One of our charges
13 is to make recommendations on how to develop a
14 sustainable workforce, and I got the hint here that
15 there is a real problem in this area. So I would
16 urge you then, as a part of this whole thing, to
17 give us at least an idea of what we might pass on
18 and help stimulate in this area.

19 CHAIRMAN HURLBURT: Linda?

20 MS. HALL: Could I add to that? I
21 think one of the things we've heard clearly from our
22 legislators is we need specific recommendations. We
23 need cost/benefit analysis types of things.

24 You have provided wonderful
25 information today, but I think what we're looking

1 for now is we need to make recommendations that
2 have data behind them that show what they cost and
3 how they will benefit.

4 MS. HEFFERN: I want to go back to
5 what David was asking. When we were first talking
6 about the need for a plan for long term services and
7 supports, truly I questioned whether or not this was
8 something that I wanted the Health Care Commission
9 to take on, because I looked at how broad the scope
10 is that you guys are looking at.

11 You've also looked at today how
12 broad long term services and supports are. I think
13 that it's a good thing for you to include, because
14 it is the cost drivers. I mean, it is a very large
15 piece of what's going to happen in our future, and
16 I applaud that you include it as something that you
17 want to have more information on, that you want to
18 include.

19 What I would suggest is that your
20 recommendation in January is just what we've said
21 today. You know, there is a group of people who
22 are in the industry, who are stakeholders,
23 consumers, et cetera, that are going to be looking
24 at the development of a plan. Not another study,
25 because Denise had talked about, over the last ten

1 years, we have done 18 of them. And those are only
2 the ones that we've been able to find right away.

3 I have a list, and I think that
4 every time that I'm done with -- you know, I've
5 gathered all of them, somebody calls me and says,
6 "Well, hey, have you heard about this one?"

7 So there is really not a need for
8 another study, but there is truly a need for us to
9 plan a system that is comprehensive, that is
10 efficient, that is sustainable, that has all of the
11 synergies of all of the providers and all of the
12 services in our state that can then go into the
13 future so that we can, you know, bend that cost
14 curve, if you would.

15 So personally, I would keep -- if
16 I was in your position -- I would keep the
17 recommendations very specific, that you're
18 supporting the need for this plan for long term
19 services and supports, but that not necessarily are
20 you going to be the ones that do that. From my
21 perspective -- you know, I, again, applaud the
22 Department of Health & Social Services for taking
23 this on, because that's where the services are. I
24 think it's a commerce and economic development
25 perspective, because there's a lot of jobs, there's

1 a lot of industry, there's a lot of people that are
2 out there that -- you know, it's like you look at
3 how much money is being spent. It's a commerce
4 issue.

5 And when you start talking about
6 it from a commerce perspective, as opposed to a
7 service perspective, you get a different way of
8 looking at it and planning it and making sure that
9 it truly is cost effective and efficient.

10 Thank you.

11 CHAIRMAN HURLBURT: Larry?

12 DR. STINSON: When we heard that
13 testimony before, we found out that air ambulance
14 services varied in Southeast by hundreds of
15 thousands of dollars for the same ride to the same
16 place.

17 If you're going to give a
18 snapshot -- and it is commerce. It's definitely an
19 economic issue -- as part of your snapshot, it
20 would be interesting to see who does this best.
21 What parts of the state do it best? What vendors
22 do it best? Who is the most cost effective and
23 why?

24 That's the kind of information
25 that would help carry the day. Whether you go to

1 commerce or us or whomever, that's the kind of
2 information that the legislators will be interested
3 in, and that might be revealing.

4 MS. ERICKSON: We don't have time
5 for more discussion, but Dave has his hand up.

6 CHAIRMAN HURLBURT: Dave, did
7 you --

8 MR. MORGAN: I would encourage
9 you -- sure. Okay.

10 I would sure encourage you to at
11 least develop in your report for May measures, some
12 kind of measures of quality.

13 MS. HEFFREN: Absolutely.

14 MR. MORGAN: So that's the road
15 we're all going down. Everybody can hire
16 accountants to do the cost, but what I've always
17 seemed to notice is we don't really have, agreed to
18 by everybody, these are the measures of quality.

19 MS. HEFFREN: We don't even have
20 agreement on the definition of who is served in the
21 definition of long term services and supports. So,
22 for me, we have to start there.

23 MR. MORGAN: Well, like I've always
24 said, like the Supreme Court on pornography: I
25 don't -- they can't define it; but, boy, when they

1 see it, they know it. So you're going to just have
2 to do it that way, I think.

3 MS. HEFFREN: Exactly.

4 CHAIRMAN HURLBURT: Thank you all
5 very much. We do need to move on to our wrap-up,
6 but that was very helpful and very clear and met our
7 needs at this time. So, thank you.

8 Deb, I'll turn it over to you for
9 the wrap-up. And, Rich, could you turn off the
10 slide, please?

11 MS. ERICKSON: Yes. That would be
12 helpful. Much better.

13 Why don't we stand up and stretch
14 for a minute, and I'm going to turn the lights up.

15
16 WRAP-UP

17
18 MS. ERICKSON: As soon as
19 Dr. Hurlburt is back in the room, we're going to
20 start, regardless of which commissioners we have
21 back in their seats.

22 But for the folks who are in their
23 seats, you might want to just turn to the last page
24 of your green agenda in the front of your book.
25 Instead of putting up a slide summarizing some of

1 the next steps, I'm just going to talk through
2 them, and then we have similar dates and issues
3 right on that page.

4 Okay. We're going to go ahead and
5 get restarted again. And, again, for folks who are
6 just sitting down, instead of putting up another
7 slide -- I had a couple of these next-step items on
8 slides, but I'm not going to put those up. But if
9 you have your last page of the green agenda open,
10 at least some of highlights are on there for now.

11 One of the things that I just
12 wanted to mention related to long term care,
13 because I heard a few comments that I think we're
14 maybe getting. And I understand that Medicaid is
15 the significant payer for long term care, but just
16 to remind the commission that our charge is not to
17 save state Medicaid dollars; it's to turn the cost
18 curve.

19 And I was just reminded of an
20 article that I read this past week out of
21 Washington, that Providence in Washington had
22 written a letter to either their governor or the
23 Medicaid director there, taking exception with one
24 of the Medicaid cuts that actually probably would
25 have benefited the Providence health system.

1 But they recognized that it was
2 going to be a scheme that was going to push in the
3 bubble on one side and push it out the other side,
4 and it was going to hurt the private payers. I
5 won't go into the details of what that scheme was,
6 but it's just something that -- as Noah was
7 reminding us, we need to understand the entire
8 system, and remember that that's our charge. So I
9 just wanted to make that point.

10 What I would like to do now is
11 just hit some of the highlights of what I noted as
12 follow-up for me, just to summarize what will
13 happen over the next couple of months; and then go
14 over our plans, just at a very high level with
15 timeline for the rest of this year.

16 And then I'll just do a real quick
17 meeting evaluation at the end and what you liked
18 about the meeting and what you want to see
19 improved. And then if we have a few minutes at the
20 end still, maybe we could go around the room real
21 quickly and just get like one closing thought from
22 every commissioner.

23 So I'm going to try to go very
24 quickly. I'm going to go ahead and e-mail and also
25 post -- we'd been posting Dr. Gawande's articles

1 when they came out last year, so we'll post that
2 one as well. And now that Rich is on board, we'll
3 have some time to do some reorganization and
4 updating on our website.

5 And I'm going to e-mail out the
6 financial disclosure form for all of you and give
7 you a deadline about a month from now. And I do
8 have, I think, at least five of them from you all.
9 So thank you for that.

10 I'll be getting out the tweaked
11 definitions that we talked about yesterday to all
12 of you over e-mail. And we'll have a follow-up --
13 maybe we'll do a one-hour teleconference sometime
14 next month and get some e-mail feedback from you on
15 those.

16 Related to health information
17 infrastructure, a number of highlights from that --
18 the general discussion around the table about
19 needing to have better data to be able to make
20 data-driven decisions and adding to the to-do list
21 for all of our consultants and future presenters as
22 well. We'll continue asking the question: What
23 are the data gaps? What data do we not have right
24 now, for whatever reason, to help us make informed
25 decisions and to be able to measure improvement

1 over time?

2 And also we'll be following up
3 initially internally with the Department of Health
4 & Social Services' health information, health data
5 experts to ask them -- to have the conversation
6 about how we are looking at the health information
7 infrastructure here and what would they advise the
8 commission as the most significant health
9 information infrastructure weaknesses right now.

10 And I made a note of the two
11 strategies that you all mentioned yesterday as
12 potential strategies that you might want to make
13 recommendations on and get a little more
14 information on: First, the need for bidirectional
15 information from the Department of Health & Social
16 Services -- not unidirectional -- and how that
17 might be improved through web portals; and if it's
18 building on the IBIS public health system, or not,
19 that we saw, or if it's something more. And also
20 the hospital discharge database specifically and
21 what issues around that, if we want to look at
22 encouraging, if not mandating participation in
23 that.

24 And I believe that was it for now.
25 I was struck, but I wanted to mention -- I'm going

1 to start off with talking to the department's
2 health information experts. However, I was struck
3 by the comments from the commission yesterday that
4 you're identifying a need that they wouldn't have
5 necessarily identified -- some of them, anyway.

6 So, at some point after having
7 that conversation internally in the department, we
8 need to continue having the conversation with users
9 of -- potential users; and whether we continue just
10 doing that within this forum or have some other
11 forum for that conversation is something we'll need
12 to figure out.

13 A couple of more general follow-up
14 questions in terms -- or issues in terms of
15 process, and some of these came out of some sidebar
16 conversations that followed from discussion
17 yesterday. As part of our future data and learning
18 sessions, we have organized our work around doing
19 continuing study and continuing learning about the
20 current systems so that we are better informed and
21 make sure that we understand the full system as we
22 work on identifying strategies and potential
23 solutions for improvement.

24 And I had been breaking those up
25 in my mind and not imagining that recommendations

1 would flow directly from these learning sessions;
2 and this meeting was devoted primarily to learning
3 sessions, except for health information technology.
4 But the discussion around and advice from all of
5 you -- that what I will begin doing, when I work
6 with speakers we're having come present to you,
7 beforehand, so we're not putting them too much on
8 the spot and they can be thinking ahead more, is
9 that we're going to be asking them, regardless of
10 whether they are just coming to inform us about a
11 particular issue or not, or whether they are
12 actually presenting on a potential solution --
13 advise them upfront what our main goals are, and
14 let them know that we're going to be asking them
15 for some recommendations.

16 And I confess -- actually, we were
17 having a sidebar conversation about this yesterday,
18 and I confessed that I needed to get a little --
19 feel a little more of a trust with this group
20 before I went that far. I was a little concerned,
21 not knowing you all and how these conversations
22 could go, that we might be a little bit too
23 reactive as a group to presenters, if we had folks
24 coming to teach us, if we just thought we needed to
25 react to every presentation we heard and every

1 recommendation we heard. I needed to learn that
2 you all weren't going to go there, I think, before
3 I had a little bit more of a sense of comfort.

4 So I will confess that but also
5 note that I, at this point, have reached that level
6 of comfort with all of you. I think we have a
7 really good group and a lot of very smart people
8 sitting around the table. And we have been hearing
9 from some of our legislators. They are already
10 impressed with all of you.

11 So in terms of the next step, in
12 the future, for these learning sessions, as well as
13 our strategy and solution sessions, we will advise
14 folks up front and just make that part of the
15 agenda, the introduction to them from us, that this
16 is what we need to do, and we're going to ask them
17 at the end, then.

18 And then also especially for the
19 data and learning sessions, allow a little bit more
20 time and also advise those presenters up front --
21 for the most part, experienced folks do a pretty
22 good job of hitting the bullets of their summary,
23 their highlights -- "This is what I want you to
24 take away from this" -- but that so-what discussion
25 at the end: What are the real highlights from your

1 presentation? What do you think the so-what
2 question is for the commission? And then allowing
3 time for you all to have a little bit more of a
4 conversation about the so-what at the end of those.

5 One other thing that I think
6 really was a sidebar conversation, again, but I
7 thought was a really good idea -- and it came from
8 Dr. Freeman's presentation during the public
9 comment period yesterday -- is how helpful it would
10 be, and we can't -- we're not going to be making
11 recommendations about specific projects along the
12 way, necessarily -- but that we could maybe start
13 telling some stories through our work, in our
14 reports and maybe even some interim writing that
15 we'll do and post.

16 So telling stories about -- to
17 highlight where there are some innovative
18 activities going on around the state, as well as
19 trying to pull some stories in about what the
20 issues and the needs are. It makes it a lot more
21 informative and interesting, and it captures folks'
22 attention more than just seeing lists of data.

23 So we will make an attempt to do
24 that over time.

25 Yes, Val?

1 MS. DAVIDSON: Just looking at our
2 statutory charge and the list of topics that are
3 going to be for future meetings, it seems like we've
4 covered all of these bases, or we will by the time
5 we get through this list.

6 But the one thing that I don't
7 think we have covered -- and it isn't on this list
8 yet -- is under "Duties," Section 2(c), "Eliminates
9 known health risks, including unsafe water and
10 wastewater sanitation systems." I don't think
11 we've had a presentation about that yet.

12 MS. ERICKSON: We have not.

13 MS. DAVIDSON: I would recommend
14 adding that to the list.

15 MS. ERICKSON: Could it go on next
16 year's list? And that's what I was asking over the
17 last three meetings, as we finalized our report for
18 this year and just listing what we were going to do
19 this year and trying to encourage folks to recognize
20 what priorities for this year were going to be, and
21 that this was going to be our agenda for this year,
22 because I'm a little concerned about getting
23 everything in in three of four more day-and-a-half-
24 long meetings. I agree. I think it's extremely
25 important.

1 DR. LAUFER: If what you're looking
2 for is anecdotal information to make an impact --
3 you were saying stories -- or about innovative
4 stuff, but -- I mean, that's clearly a place
5 where --

6 MS. ERICKSON: Well, I mean, there
7 are important needs and programs for addressing
8 those needs --

9 DR. LAUFER: Oh, okay.

10 MS. ERICKSON: -- that we would
11 want a presentation on --

12 DR. LAUFER: Oh, okay. From --

13 MS. ERICKSON: -- and actually put
14 in the report, include in the report -- yes, Keith?

15 MR. CAMPBELL: Well, in that
16 regard, I see Joel Neimeyer stopped in this
17 morning -- the Denali Commission is meeting across
18 the hall -- and there, that's a biggie for them, so
19 it is being addressed. But we could get information
20 from them and work it into our thing in next year's
21 or something.

22 MS. ERICKSON: In next year's?

23 Val, is there something pressing
24 during this calendar year that the commission could
25 add value right now, rather than waiting until

1 2012?

2 MS. DAVIDSON: I think we could
3 probably wait till 2012. I guess the concern that I
4 have is that the federal trend is falling. The
5 state right now provides a 25 percent match, which
6 has been fine for historically, when the federal
7 level has maintained where it is. But now that the
8 federal amount is dropping, the state corresponding
9 amount isn't increasing to be able to meet that
10 demand.

11 So, yeah, that can wait. I guess
12 I'm just concerned about the public health impact
13 it's going to have in the meantime.

14 MS. ERICKSON: Is there --

15 MS. DAVIDSON: So I think it can
16 wait --

17 MS. ERICKSON: Is there something
18 on the list that folks would feel comfortable taking
19 off? I was wondering if we could replace the trauma
20 system development -- if there is anything that the
21 commission would do to add value to the process
22 that's going on for trauma system development, if we
23 should take that off and put sanitation on.

24 MS. DAVIDSON: I hear you. I hear
25 you. It can wait another year.

1 MS. ERICKSON: Pat?

2 MS. DAVIDSON: I hear you.

3 MR. BRANCO: Well, not to throw the
4 baby out with the bathwater, but the hospital
5 association is pretty heavily invested in the trauma
6 system and doing the work there, that I think that
7 could forego a year's attention by the commission.

8 MS. ERICKSON: The trauma system
9 could?

10 MR. BRANCO: I think that could
11 delay by a year and elevate this one to the
12 forefront.

13 MS. ERICKSON: Larry?

14 DR. STINSON: In the relative
15 importance of things, the trauma system is
16 important, but basic safe sanitation and water is
17 the hugest public health problem there is.

18 MS. ERICKSON: So would somebody
19 like to make a motion that we postpone trauma --

20 COL. FRIEDRICHS: If I may, I'll
21 offer the alternative from the federal standpoint,
22 that one of the things that will impact whether we
23 remain with our presence in Alaska is whether or not
24 Alaska builds a trauma system. So as you all
25 consider what you will do, understand what we are

1 considering we will do; and that's one of the
2 reasons why we brought that up.

3 MS. ERICKSON: Val?

4 MS. DAVIDSON: We can wait another
5 year.

6 MS. ERICKSON: For sanitation?

7 MS. DAVIDSON: I think it's
8 unanimous.

9 MS. ERICKSON: We will not forget
10 sanitation. I'll make a note of that. Okay. So
11 really --

12 MS. DAVIDSON: So the other is in
13 terms of dates, meeting dates.

14 MS. ERICKSON: Well, that's what I
15 was going to go over next.

16 MS. DAVIDSON: I wasn't sure where
17 you were in your list.

18 MS. ERICKSON: I have June 23rd and
19 24th and August 25-26. I heard nothing back from
20 anybody, putting those dates out a couple times,
21 that that was a problem. So I don't even have those
22 really listed as tentative anymore. So I'm
23 hoping -- I'm hearing -- I'm seeing nods and thumbs
24 up. I'm hoping that works for folks. Seeing all
25 nods.

1 I did hear back on the
2 October 20th and 21st dates. I wanted to have that
3 meeting as late in October as possible. The
4 alternate days that worked for the person I heard
5 from and also worked for both Dr. Hurlburt and for
6 me were October 11th and 12th.

7 Yes, Jeff?

8 MR. DAVIS: I don't know if it was
9 me you heard from, but the 11th and 12th will work
10 for me.

11 MS. ERICKSON: So do all of you
12 know right now if the 11th and 12th works for you?
13 It does not work for one person. I'm seeing nods.

14 What I will do -- I haven't had
15 great response from -- on my -- on that little
16 online survey tool that I thought was going to be
17 so cool, so I'm just going to do an e-mail and do a
18 poll over e-mail and get the greatest number for a
19 quorum on those two dates. Okay?

20 Would you write that down, Rich,
21 so I don't forget what I said I'm going to do?

22 DR. LAUFER: Can I ask a real quick
23 question?

24 MS. ERICKSON: Quick question.

25 DR. LAUFER: You know, there are

1 one-year, two-year, three-year appointees. I'm
2 wondering --

3 MS. ERICKSON: There are. We're
4 staggered right now.

5 DR. LAUFER: -- when does that year
6 end?

7 MS. ERICKSON: The year ends at the
8 end of this calendar year.

9 DR. LAUFER: Okay.

10 MS. ERICKSON: And right now, our
11 schedule is moving towards getting on a regular
12 schedule, where we will have quarterly meetings in
13 February, May, August, October. We'll use November,
14 the full month of November, as our public comment
15 period; have one more quick one-day meeting in early
16 December to consider public comments, finalize the
17 report by December 15th, and we're done by
18 December 15th with our January 15th report.

19 So that's our schedule for --
20 we're squishing together. And that's my apology
21 that we're having two summer meetings this year,
22 because everything was compressed again.

23 DR. LAUFER: There's nothing fun to
24 do in the summer in Alaska.

25 MS. ERICKSON: I apologize.

1 So that's it for the meeting
2 schedule. And I was just going to review
3 quickly -- one thing, just quick dates if you want
4 the make some notes, just some related issues and
5 activities you might be interested in. April 6,
6 next Wednesday, is the final Medicaid Task Force
7 meeting in the afternoon. You can get more
8 information from me or just by Googling "Alaska
9 Medicaid Task Force" and finding the website.

10 On April 13th, Commonwealth North
11 is having a luncheon. And they have the UAA debate
12 team going to debate the constitutionality of the
13 individual mandate, so that might be an interesting
14 forum to attend. I hear the debate team is
15 excellent. So I thought you might all be
16 interested in that.

17 I told you about this health care
18 reform conference, "The State of Reform," that's
19 being planned. And the date keeps changing, but I
20 think it's set now, and it's now set for
21 September 30th, one day in Anchorage. So I will
22 send those dates out over e-mail, too, so you have
23 them, if you are interested in participating.

24 For upcoming meetings, we're not
25 going to talk about this too much right now. I

1 want you to e-mail ideas to me. But I'm shooting
2 for making our June meeting focused on the solution
3 end of medical homes and ACOs. And we'll be
4 talking with North Carolina. There is a model
5 there for medical homes that is for a system that
6 looks more like our health care delivery system
7 here; not integrated, but it's a medical home model
8 system that's set up to support small-group
9 practices and individual practices.

10 And so I'm looking at bringing
11 somebody from that organization up to present to
12 all of you. And I asked Jeff last week if he maybe
13 could help us get ahold of some of the -- Blue
14 Cross Blue Shield, across the country, has been
15 doing a number of pilot projects; and most recently
16 we've been hearing in the news about how successful
17 the Michigan pilot project was.

18 I don't know if that is the best
19 one or not, but I'll follow up with Jeff to see if
20 we can find somebody from the private health
21 insurance industry who has been piloting this to
22 come up and present during that session as well.

23 So if any of you have any other
24 ideas about what we might -- who we might bring or
25 what you want to focus on in the learning session

1 on potential solutions around medical home model
2 and ACO development. If June works for our outside
3 speakers, we'll shoot for that. Otherwise, it
4 might be later in the year, the August meeting; no
5 later than the August meeting.

6 The other area of strategy that we
7 were looking at was price and quality transparency.
8 And as Ward and I had talked about that, we really
9 were hopeful that we could get at least some
10 preliminary results from the pricing and
11 reimbursement consultant prior to having that --
12 learning about solutions around price and quality
13 transparency. We may or may not do that, but
14 that's also on our list for this year.

15 Health status of Alaskans was
16 another learning session that you all had requested
17 this past year. And Dr. Hurlburt and Melissa
18 Stone, who is the director of the Division of
19 Behavioral Health, are actually planning on giving
20 you all a presentation on that at our next meeting.

21 I'm not going to go down this list
22 any further, although I did want to note, Workforce
23 Development -- I've started participating in the
24 monthly meetings of that coalition so I make sure
25 I'm tied in and bring information to all of you.

1 I'm pretty excited about some of the stuff they are
2 doing, especially around cross-industry
3 partnerships with mining and oil industry, around
4 education reform for K through 12, and -- there's
5 some cool stuff going on.

6 So you are going to get an update
7 from that group when they are ready to release
8 their next plan in probably August, I would
9 imagine.

10 And around leadership, as I
11 mentioned before, Commissioner Streur really
12 regretted not being able to be here and intends to
13 be here as much as possible, as well as our new
14 state -- well, was our new state Medicaid director
15 for two weeks and now she's our deputy commissioner
16 for Medicaid. But she's in Baltimore at Medicaid
17 meetings this week.

18 So that went a little bit too
19 long. Just real quickly, because I want to give
20 you all a chance to say a parting thought, is there
21 one or two things that we could do better next
22 time? We won't even focused on what you liked.
23 Anything that you would suggest that we -- yes,
24 Noah.

25 DR. LAUFER: I think we need to

1 listen to Dr. Friedrichs and move on to the solution
2 section.

3 I got to go to a meeting at
4 Providence and Ted Stevens was there, and, you
5 know, he knew it was going to be a bunch of whining
6 from the doctors. And he gets up, and he kind of
7 grumbled. And he said, "Okay. Does anybody have
8 any constructive ideas or solutions in regard to
9 Medicare?" And there was silence. And he said,
10 "Okay. I won't be taking questions on Medicare."

11 And, you know, I couldn't believe
12 it, but I really admired that. And that is where
13 we are.

14 MS. ERICKSON: Yes. I wrote that
15 down.

16 Val?

17 MS. DAVIDSON: So I'm hoping
18 that -- sometimes it feels like, in the meetings, we
19 get to the juicy stuff at the end. We're really
20 doing a lot of sitting; and I think, if you looked
21 at today, there was a lot of -- and yesterday --
22 there was a lot -- the meeting was really passive.
23 There wasn't really a lot of time for discussion.
24 We listened for, you know, two hours or an hour, and
25 then we talk. And everybody would try and get in

1 their thoughts in like 30 minutes or 20 minutes.

2 So it might be nice to have more
3 of a -- because when people are presenting, they'll
4 present for days if we give them the opportunity
5 to; but they'll take as much time or as little time
6 as we allow them.

7 And I think if we're more
8 disciplined, like what Paul was talking about --
9 okay. "Give us a quick snapshot." And maybe they
10 can give us whatever their documents are to read in
11 advance or whatever about what it is that they're
12 talking about. But if they really have a focused
13 presentation on what the recommendations are, we'll
14 have more opportunity to talk among ourselves.

15 The other thing I want to be
16 careful about is that it feels like we have lots of
17 learning opportunity throughout the year, but the
18 most critical time, which is when we're formulating
19 our recommendations, we're just scrambling, and we
20 get a draft that we have moments to review.

21 And so I think a part of it is
22 that, you know, we're all busy -- and I'm not being
23 critical. You guys are doing fabulous work. But
24 at some point we have to have more opportunity for
25 discussion about what it is that we want it to look

1 like.

2 And the other is, we need to be
3 able to have more time to look at what the document
4 is before it goes public so that we're not in a
5 position of being sort of in the awkward position
6 of having to publicly comment that there may be a
7 part of the report we don't necessarily agree with.

8 CHAIRMAN HURLBURT: Let me ask a
9 question about your comment, because we're going to
10 have people present to us that are very passionate
11 about what they do. And you're absolutely right:
12 Every one of them can go on for days and days,
13 because their heart is really in it.

14 But my observation is -- and I
15 think you're right. We were more in a
16 listening/learning mode this time, and we end up --
17 and the most valuable thing we can do is the
18 discussion, and maybe we can do that by sharing
19 more information in advance.

20 But a question is -- and we'd all
21 have to discipline ourselves -- my observation is
22 that we slow the presentations a lot by questions
23 from the group to the presenters, and that
24 dramatically slows them down. It makes it hard to
25 keep on schedule.

1 Now, it gets our questions
2 answered right away, but it does make it very
3 difficult for them to get through and to keep to
4 the time schedule when we do continually interrupt
5 the questions.

6 Yes, Paul?

7 MS. ERICKSON: We have one minute
8 before we need to adjourn so folks can get to the
9 airport. So I guess I didn't have anything else.
10 We've lost the time for all of you to give your
11 final thought.

12 I tell you what. Let's go around
13 the room. I've give you your chance for a final
14 thought; and if whatever you had your hand raised
15 about right now you want to --

16 CHAIRMAN HURLBURT: Start with
17 Paul.

18 COL. FRIEDRICHS: Well, thank you,
19 Mr. Chair.

20 I understand and appreciate your
21 concern. I think what Val had suggested would have
22 prevented the need for the interruptions and the
23 questions. If the presenters --

24 MS. ERICKSON: Were more focused?

25 COL. FRIEDRICHS: -- were more

1 focused on answering the questions that we know we
2 have to answer, we wouldn't have to ask the
3 questions and help to focus them during the
4 presentation.

5 The second thing that I would
6 share with the group -- it will be publicly
7 announced, I think next week, that I've been
8 confirmed as the next Pacific Air Force's surgeon.
9 I plan to remain an Alaska resident and do hope to
10 remain involved with the commission here. I'll be
11 responsible for health care throughout the Pacific,
12 including Alaska, and I believe that that is
13 permissible as long as I'm an Alaska state
14 resident.

15 But I would ask the Chair -- and I
16 want everybody to be aware that I'm asking it very
17 publicly so that there is no question about trying
18 to scooch the system in some way. But that will
19 mean that I will be physically moving to a new duty
20 location in July.

21 MS. ERICKSON: Congratulations.

22 (Applause.)

23 CHAIRMAN HURLBURT: I think that
24 the question -- and Deb and I will probably have to
25 talk with you -- will be a relationship related to

1 the VA, because the Legislature did designate that.
2 I talked with Alex about that.

3 MS. ERICKSON: We'll have --

4 CHAIRMAN HURLBURT: Alex was
5 delighted. But we can have that conversation --

6 MS. ERICKSON: We'll have a
7 follow-up conversation.

8 Noah?

9 DR. LAUFER: Adios.

10 MS. ERICKSON: Jeff?

11 MR. DAVIS: Okay. I've been quiet
12 this time, so I will take this chance.

13 A little dissent on some of the
14 earlier comments. I think detail is really
15 important; but I think we've solved the problem of
16 focus with what we've already talked about, so
17 that's great.

18 Group process. These guys seem
19 like they're a long ways away (indicating other
20 commission members). So I don't know if there's a
21 way to -- because we've gotten so big -- kind of
22 scooch us together. I think that would help with
23 discussion.

24 And perhaps spending some time --
25 I don't know if this is permissible in the public

1 process -- but spending some time together not in a
2 meeting, a public meeting. You know, like let's
3 have dinner. Let's, you know, have a glass of wine
4 or something, just so we spend time together. I
5 think that would help improve the dynamics of the
6 group. Not that it's bad, but I think we could be
7 better.

8 Thanks.

9 MS. ERICKSON: Thank you.

10 Val, your final thought.

11 MS. DAVIDSON: I think I've said
12 plenty.

13 MS. ERICKSON: Pat?

14 MR. BRANCO: I've said enough. I
15 pass.

16 MS. ERICKSON: Keith? Larry?

17 MR. CAMPBELL: Pass.

18 DR. STINSON: Pass.

19 MS. ERICKSON: Emily?

20 MS. ENNIS: Pass.

21 MS. ERICKSON: Dave?

22 MR. MORGAN: I'll pass.

23 MS. ERICKSON: Dr. Hurlburt, for
24 the good of the order, we'll let you wrap us up.

25 CHAIRMAN HURLBURT: Okay. Thank

1 you all for coming. Thanks for participating, and
2 God speed going home.

3
4 (Meeting adjourned at 11:04 a.m.)

C E R T I F I C A T E

S T A T E O F A L A S K A)
FIRST JUDICIAL DISTRICT) Ss.

I, LYNDA BATCHELOR BARKER, Registered Diplomat
Reporter and Notary Public duly commissioned and
qualified in and for the State of Alaska, do hereby
certify that the foregoing proceedings were taken
stenographically before me and thereafter reduced to
typewriting by me or at my direction.

That the foregoing transcript is a full, true
and correct transcript of the proceedings, including
questions, answers, objections, statements, motions and
exceptions made and taken at the time of the foregoing
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That all documents and/or things requested to be
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That I am not a relative or employee or attorney
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proceedings or the outcome thereof.

IN WITNESS WHEREOF, I have set my hand and
affixed my Notarial Seal this 7th day of
April, 2011.

LYNDA BATCHELOR BARKER, RDR,
Notary Public for Alaska
My commission expires: 5/6/2012