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ALASKA HEALTH CARE COMMISSION

THURSDAY, AUGUST 25, 2011

8:00 A.M.

FRONTIER BUILDING, ROOM 890-896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 1

PAGES 1 THROUGH 266

1 colleagues, something that we want to do well in Alaska this
2 year and keep Alaska healthy.

3 So if we could maybe start and go around the table, here,
4 David, so if we could start with you? Want to turn on your
5 speaker?

6 COMMISSIONER MORGAN: Yeah (affirmative). Dave -- I feel
7 like I'm in front of the Senate, you know. Dave Morgan
8 representing Alaska Primary Care Association seat.

9 COMMISSIONER STINSON: Larry Stinson, a physician with
10 clinics in Wasilla, Fairbanks, and Anchorage.

11 COMMISSIONER KELLER: Wes Keller, a representative of
12 Alaska State House.

13 COMMISSIONER HALL: Linda Hall, Director of the Division
14 of Insurance representing the Administration and the Governor.

15 COMMISSIONER CAMPBELL: Keith Campbell. I'm the consumer
16 representative on the Commission. I reside in Seward.

17 COMMISSIONER ERICKSON: Before we move on, can I ask --
18 make sure that you not only have the button pushed, but that
19 you're holding your mouth pretty close because I'm not able to
20 hear some of you with your speaker on. So you just have to be
21 pretty close to the mic. Thanks.

22 COMMISSIONER DAVIDSON: Good morning, Valerie Davidson
23 representing tribal health.

24 COMMISSIONER BRANCO: Good morning, Pat Branco
25 representing the Alaska State Hospital and Nursing Home

1 Association.

2 COMMISSIONER HIPPLER: Allen Hippler, State Chamber of
3 Commerce.

4 COMMISSIONER LAUFER: Noah Laufer, a family care doctor
5 in Anchorage, primary care.

6 COMMISSIONER ERICKSON: Deb Erickson, Executive Director,
7 Alaska Health Care Commission.

8 CHAIR HURLBURT: And I would like to offer a special
9 welcome to Allen who joins us with his first meeting here.
10 We're very pleased and fortunate that you've been selected and
11 are willing to do this, Allen, and we welcome you to the
12 important work that we're doing.

13 If we could start with the audience now, just introduce
14 yourselves, and if you have an affiliation you want to say, go
15 ahead.

16 (Audience introductions indiscernible - away from mic)

17 CHAIR HURLBURT: Tom, we're just -- the audience is just
18 introducing themselves. Thank you very much, Tom. And our
19 friends over here are keeping us going, if you want to
20 introduce yourselves.

21 (Introductions indiscernible - away from mic)

22 CHAIR HURLBURT: Great. Thank you both for being here
23 and for your support. Deb, can I -- oh, okay.

24 COMMISSIONER ERICKSON: Jeff is asking where he should
25 sit. Sorry. Why don't you come sit by Noah?

1 CHAIR HURLBURT: He can tell you if you owe him any
2 money.

3 COMMISSIONER DAVIS: (Indiscernible - away from mic)

4 CHAIR HURLBURT: Jeff, we're just going around. Could
5 you introduce yourself?

6 COMMISSIONER DAVIS: Good morning, I'm Jeff Davis,
7 Premera Blue Cross Blue Shield of Alaska.

8 CHAIR HURLBURT: Thank you. Deb, can.....

9 COMMISSIONER ERICKSON: Do you want me to take it or were
10 you going to -- did you want to do something related to the
11 flip chart?

12 CHAIR HURLBURT: No. No. That was what I said about the
13 flu. That was all. Yeah (affirmative).

14 COMMISSIONER ERICKSON: So we're ready to move on to the
15 agenda?

16 CHAIR HURLBURT: Yes. Yeah (affirmative). Right on
17 time.

18 COMMISSIONER ERICKSON: Just a couple of things. A few
19 things before we get started with our first session this
20 morning. I'm not going to go over the agenda in any detail.
21 You all have had a chance to see that for a few weeks now.
22 Nothing substantive has changed. We just had a few people
23 confirm, and the blue agenda that was in your new handout
24 packet is the final, final agenda. And I just want to make
25 sure that all of the Commissioners, all of you have picked up

1 one of these packets because those are the additional handouts
2 to add to your notebook that have come in since your notebook
3 was sent out. So make sure you pick that up. I noticed that
4 there were still several there. I also just put out another
5 handout. There's separate pile at the end of the table there,
6 and there's also a stack for folks in the room on the handout
7 table. But just a little commercial on behalf of the T-Chick
8 (ph) project that's working on Patient-Centered Medical Home
9 initiative in-state, and they're hosting a day-long work
10 session on medical homes and linking quality improvement.
11 It's a learning opportunity. Any of you who might be
12 interested, it's for a full day on September 14th at the
13 Alaska Native Heritage Center here in Anchorage. So that's
14 just a note about that.

15 As far as our agenda for the day, again, I'm not going to
16 go over it in any detail, but I would just refer you to page
17 two of our strategy for transforming health and health care,
18 page two, our 2011 priorities, priorities for this calendar
19 year. All of our sessions today link directly to one or more
20 of our priorities for this calendar year, and I mention that
21 for the audience as much as for anybody else so they can have
22 a little bit of context about what we're doing.

23 So I think -- one more thing, books. We did order extra
24 books on tracking medicine and got those to the folks who had
25 indicated at the last meeting that they would like a copy

1 after we ran out, but we have a couple more. If anybody else
2 wanted to pick up one of those books, I have them up here.

3 Also, we ordered for all of the Commission members, a
4 book that is a little dated, but I think it was enough ahead
5 of its time that it's really now just starting to hit stride
6 in some respects. The Institute of Medicine, ten years ago,
7 produced a study on quality in health care, crossing the
8 quality chasm. So it's ten years old, but a couple of things
9 related to this book. There are a couple -- quite a few
10 recommendations in this book that are very related, or at
11 least, relevant to our priorities and the strategies that
12 we're studying. So I thought you would find that interesting
13 and informative. And as well, you might notice, if you take
14 some time to read this book, that the level of policy
15 recommendations that Institute of Medicine committees make are
16 very similar to kind of the level and scope of recommendations
17 that we've been making. So nothing more about that book.
18 Does anybody have any questions before we get started? If
19 not, I think we'll just dive right in.

20 We had a teleconference, since our last meeting, to spend
21 some more time shaping up some Finding and Recommendation
22 statements related to areas that we studied at our last
23 meeting in June and so that's what we're going to spend the
24 first part of the morning today going over. And I really --
25 and this group has actually been pretty good about it. I

1 probably don't need to say anything, but we don't want to
2 spend much time word smithing. We just want to make sure that
3 the concepts look good, and we can do any word smithing over
4 email, if we need to do that later on.

5 Just a point about timing and process too, a reminder
6 that anything we come up with today is still draft and it will
7 continue to be draft. At our next meeting in October, we're
8 going to have fewer learning sessions than we normally have in
9 these meetings and a lot more time for discussion to wrap up
10 and to get to a point where you all feel comfortable releasing
11 for public comment all of the Findings and Recommendations for
12 our 2011 report. Then we'll have a month-long public comment
13 period on the complete draft of all of our Findings and
14 Recommendations for this year before we come back together
15 again and finalize and approve those in December, at our
16 December 9th meeting. So just a note about where we're at in
17 terms of process and timeline with our Findings and
18 Recommendations. Any questions about process and timeline?

19 Well, let's dive right in then. Let's look at Patient-
20 Centered Primary Care first. You had all of these Finding and
21 Recommendation statements in your notebook. There is nothing
22 changed here in the slides that I have up, but in terms of the
23 findings, I had worked to capture all of the concepts that we
24 discussed on our teleconference and had already circulated
25 these over email, and so hopefully, you've had a chance to

1 take a look at them.

2 Just generally -- oh, maybe it would have been helpful if
3 I had numbered these bullets, but the first few bullets under
4 Findings are related to the importance of primary care and the
5 importance of having a strong primary care and patient-
6 centered primary care system to improving health and lowering
7 per capita cost of health care, the importance of care
8 management and good, strong evidence-based care management,
9 especially for patients with complex health conditions, and
10 the value and control in costs in improving health through
11 care management. And the next couple of bullets really are
12 meant to define what we mean by patient-centered and then
13 noting the importance of the relationship of patient-centered
14 primary care to the community and to public health and other
15 social service providers. So that's kind of the first couple
16 sets of findings.

17 And then we move into findings related to the learning
18 that we had, that there are a number of innovative programs
19 that have been implemented in other states as well as other
20 organizations, federal organizations. Keith?

21 COMMISSIONER CAMPBELL: In going through, it struck me
22 that -- I guess it's not clear, to me, what the glue is that
23 holds this patient-centered model together, other than the
24 massive bodies that are involved in taking care of a patient
25 because, recognizing that you get nurse practitioner turnover,

1 you get M.D. turnover in all of these -- your potential, at
2 least, in rural areas more than here in town, and I just
3 wonder if we ought to give some thought on maybe how the
4 Administration is going to be passing along this information
5 from M.D. practitioners on down to their successors, if any.
6 I don't have any answer, just that question popped into my
7 mind.

8 COMMISSIONER ERICKSON: Could you restate that?

9 COMMISSIONER CAMPBELL: Probably not.

10 COMMISSIONER ERICKSON: I'm not sure I understood.

11 COMMISSIONER CAMPBELL: All right. Let's say you have --
12 at least my concept of the medical home model, you have a M.D.
13 You have, presumably, a clinic operation of some sort. You
14 have the supporting staff. You've got the R.N.s. You've got
15 whoever it might take to administer this or provide the care
16 because it is supposed to be continuous and loving and all
17 this sort of thing, but if a major player or two major players
18 are not there, who brings and consolidates all of this
19 information and still has that connection with the patient to
20 pass on the preceding history, you know, other electronic
21 medical records and all these kinds we kind of understand, but
22 is there some firmament that really passes that history on
23 down to any succeeding practitioners? I guess it's not clear,
24 in my mind, how that happens. Maybe -- well, Val,
25 (indiscernible - voice lowered).

1 COMMISSIONER ERICKSON: Val?

2 COMMISSIONER DAVIDSON: Typically, it's the case manager
3 who is assigned to that group of providers that really manages
4 that information and so, if your doctor or your provider or
5 your mid-level is unable, the case manager and the people who
6 work with the case managers are the common link.

7 COMMISSIONER ERICKSON: So is there a finding that we
8 need to add that addresses this?

9 CHAIR HURLBURT: There might be a little more discussion.
10 Go ahead.

11 COMMISSIONER LAUFER: The question is the heart of the
12 matter, really, and there are a lot of different ways to do
13 it, but most people don't go to an institution for care. They
14 go to some body for care and that's why I've been a little bit
15 of a blowhard firebrand about this.

16 What we have been able to do or are trying to do -- and I
17 think where the kernel of value in this patient-centered
18 medical home is, is in this relationship, and it's a personal
19 one. So the way we're doing it is Dr. Jones, our founder,
20 retired. People are shocked and offended that, even though he
21 was in his 70s, he was going to quit. He wrote on a business
22 card my name or one of my other partners or somebody else, and
23 patients come and they interview me to see if maybe I'm going
24 to be up to their standards. It's personal, and this is the
25 problem with trying to, you know, increase productivity or

1 handing the autonomy of the physician over to any other -- or
2 nurse practitioner or case manager or whatever -- entity is
3 it's gone. There is a great value in sitting around and
4 shooting the breeze for a few minutes with somebody that
5 you've known for a few decades. I don't know what you can
6 charge for that or what a reasonable reimbursement is for
7 that, but that's the kernel of it. And this is a fight right
8 now over whether we're going to spend huge amounts of money
9 purely on technology and bigger systems and greater algorithms
10 and all that or whether we're going to lose the secret of
11 caring for people, which is caring.

12 CHAIR HURLBURT: I think, simplistically, I look at
13 medical home -- and I think you've heard me say it -- it's
14 what you really always wanted your doctor to be. You want a
15 long-standing, longitudinal relationship there with a
16 physician or it could be a nurse practitioner or P.A., I
17 guess, but who has a sense that they have a responsibility and
18 a commitment to you for your overall care and you feel that
19 relationship there. And I think the model will vary, and it
20 will vary in Alaska where, you know, for the most part, our
21 practices, particularly in Anchorage here, are small. We
22 don't have groups of physicians as much as some other places
23 do, but we can look just what's at this table here, and we'll
24 see a variation. I think, where Noah has talked about his
25 practice where they're basically building up on themselves

1 over many years, they've invested the money there, but clearly
2 have this very deep commitment to their patients, and I
3 assume, intense loyalty from the patients reciprocating that,
4 but a feeling, we need to really help these patients through
5 their life whether it's wellness things, whether it's
6 directing them to the appropriate non-primary care specialist
7 when they need to, but then there's a very different model
8 that David and Val represent here. I feel I'm fortunate to be
9 able to go to the SouthCentral clinic as a retired commission
10 officer, and every time I go, I'm blown away at how good that
11 program is there and what they're doing. Very different
12 models, but I think both are addressing some of the essence of
13 the medical home. Noah -- without the case manager that Val
14 talked about because you don't have that size business and
15 structure to do that, but to me, they both meet the heart and
16 intent and the center of what a medical home is. Noah, yeah
17 (affirmative)?

18 COMMISSIONER LAUFER: I feel like I need to clarify a
19 little bit. That's true; we don't have the money for case
20 managers, but we don't -- we can't solve all the problems, and
21 you know, when the going gets tough -- say I've seen you for
22 30 years and I figure out that you're about to have a heart
23 attack, I'm not a cardiothoracic surgeon, and I can't put a
24 stent in, and I need the hi-tech stuff to do it. You know, I
25 could console you and give you morphine. That's -- when

1 medicine was really cheap, that's what they did, you know, a
2 little morphine and oxygen and prayer and maybe you would
3 survive, but that's not the world we live in now, and I do
4 need good access to, you know, highly skilled specialists to
5 provide what I think is good care and that costs money. I
6 don't, by any means, mean to denigrate what they do, but if
7 we're talking about patient-centered medical home, that's a
8 different issue.

9 COMMISSIONER KELLER: Another element, I think, is
10 understood by everybody, but I just want to throw it in and
11 that is the element of responsibility of the patient. The
12 top-down case manager doesn't really fit the model, you know.
13 If the patient is engaged and comes to see Noah's clinic,
14 let's say that patient moved to a different area, there is
15 some level of responsibility on that person to find a caring
16 doc or a case manager that cares and fits in. So there are
17 two levels of this. That's all.

18 COMMISSIONER DAVIDSON: I think, whether we call them a
19 case manager or a doctor or a mid-level provider, you're still
20 managing the care of your patient, and the question is, who do
21 you want to do that? Do you want the doctor to do that? Do
22 you want the mid-level to do that? Or do you want someone
23 else to do that? And really, I mean, every practice makes
24 that decision for themselves and that's the great thing about
25 America is you can choose your own model. It's really a

1 matter of how you want to structure that and what works for
2 you and what works for your population for your patients. But
3 I think the third bullet on page two really covers sort of
4 that flexibility, where you talk about the clinical team and
5 the patient. I think clinical team is pretty broad and
6 probably covers every range of possibility you could envision.

7 CHAIR HURLBURT: Well put. Thank you. Keith, do you
8 have any other comment reacting to this? You kind of started
9 the discussion?

10 COMMISSIONER CAMPBELL: Well, I thought we'd try to wake
11 everything up this morning, but my only thought is that
12 everything that has been said is pretty much true, except that
13 there is a great amount of turnover, particularly in the rural
14 communities in these practices. And I guess I just -- the
15 question occurred to me, how -- without expensive case
16 managers, who is the glue that passes all of this history?
17 You know, you can go through a stack -- you know, I haven't
18 looked at my medical record lately, but it's -- you know, I'm
19 one of the older guys in the room, and it's pretty high, I
20 suspect. And to expect a brand new physician, the first time
21 they see me, to go through a stack of medical records without
22 somebody bringing the pertinent facts forward in some sort of
23 a concise record is pretty daunting, and if you're going to do
24 that for several hundred people as a brand new practitioner,
25 things tend to drop down a crack.

1 So I'm just wondering, in my own mind, how we get -- and
2 I think medical home is a great thing, and as I've said
3 before, I think a lot of it has already happened, particularly
4 in the smaller communities, but how do you pass this
5 information down so that bad things don't happen inadvertently
6 to people? That's what triggered my thought this morning
7 because there is great turnover in these small communities,
8 particularly.

9 COMMISSIONER ERICKSON: Keith, do you think that
10 something has changed over the past few decades? What's
11 different today related to that sort of turnover and how it
12 affects a rural community compared to 20 or 30 years ago?

13 COMMISSIONER CAMPBELL: How far do you want me to go
14 back, to the Middle Ages? Well, as one of the few people who
15 practiced health care administration before Medicare, yeah
16 (affirmative), I've got a fair history and things have changed
17 greatly. The Noahs of the world, with very few exceptions,
18 don't work 18, 19, 20 hours a day, make house calls, and this
19 sort of thing, like they did in the old days. In our town in
20 my early years in Seward, the docs were there. They were on -
21 - they staffed the hospital. They, you know, had to live
22 within -- by medical bylaws, they had to live within 15
23 minutes of the hospital. They did everything. Now, you have
24 weekend coverage. I mean, it's a horribly expensive medical
25 model for a small town, like Seward. You've got the people

1 holding the clinic. Then you've got a guy maybe manning the
2 ER. Well in the ER rotation in the wintertime, he won't see
3 three or four patients in 24 hours, but he gets 48 hours off.
4 You talk about expensive overhead. In the older days, that
5 was an assumed part of practicing medicine and that's no
6 longer so. They work 40 hours a week, if that, or share a
7 practice. All these kind of expensive things that they may be
8 as dedicated, but in my early years, I never saw a doc work 40
9 hours a week and I suspect I never had only a 40-hour week in
10 most of my working career. Things have really changed in
11 medicine.

12 CHAIR HURLBURT: Noah?

13 COMMISSIONER ERICKSON: Noah?

14 COMMISSIONER LAUFER: I, obviously, agree. There are a
15 lot of really good questions to ask. I like Seward. I cannot
16 go down there as a private physician and hang a shingle, and
17 the question of why is really important. I cannot compete
18 with a clinic which is subsidized by a bigger entity. Last
19 night when I went home at 9 o'clock, I was in the grocery
20 store and got cornered by a couple, and the wife really wants
21 me to address her husband's excessive snoring and probable
22 sleep apnea, and I've known them for a while, and you know, it
23 goes on and on because I am a figure in the community. If I'm
24 a temporary employee of a huge entity which sucks all the
25 oxygen economically out of a community, it's not possible for

1 someone, like that, to practice in Seward.

2 COMMISSIONER ERICKSON: Val?

3 COMMISSIONER DAVIDSON: I'm going to try one more time to
4 get us back on track. So what specific changes do we need to
5 make to these findings to address those concerns or have they
6 already adequately been addressed?

7 COMMISSIONER ERICKSON: Well, one thought I had or
8 question for all of you that I don't believe is captured in
9 the findings right now is how both -- and something that, I
10 think, we learned through our webinars -- I learned through
11 our webinars; most of you probably already understood this was
12 how -- what's different today compared to when we had doctors
13 who would make house calls and had that kind of relationship
14 in the community between a family and physician is how
15 medicine has evolved due to the increase in knowledge and
16 complexity about health and medicine, how much more
17 specialized it's become, how much more knowledge there is to
18 manage on the part of the physicians, and then on the other
19 side -- so medicine has evolved significantly. At the same
20 time, patient needs have shifted from more acute care to more
21 chronic care and the type of care that those sorts of
22 conditions need is different from somebody who has the flu or
23 an injury. Do you think it's important -- to our discussion
24 about patient-centered primary care, and ultimately, the
25 recommendations we're going to make -- to describe that

1 capture in some way in a finding statement? Val?

2 COMMISSIONER DAVIDSON: I guess the findings are
3 interesting, but just like all of the whereas clauses in a
4 resolution, the now therefore be it resolved is the
5 recommendation section, and I think I would prefer to spend
6 more time in the now therefore be it resolved section or the
7 recommendations.

8 CHAIR HURLBURT: Is it acceptable to move on? Okay.

9 COMMISSIONER ERICKSON: One of the things I just wanted
10 to note though is we did try to capture -- and I want to
11 mention this because, if you think it's important enough that
12 it be captured in a recommendation rather than a finding, if
13 you look at slide six in your handout and also slide -- so
14 slides five and six, these were the two longer findings where
15 we bulleted out some of the learnings from our webinar series.

16 The first on slide five was a series of the elements that
17 we identified as what was essential to these innovative
18 programs we studied to starting a successful initiative, for
19 example, financial investment up front by the initiating payer
20 organizations, but a long list there, and then elements that
21 we thought were important investment strategies that seemed to
22 be common to all of those successful initiatives, so for
23 example, providing a shared learning environment for the
24 clinical teams, the importance of timely data. Do you think
25 that that learning is important enough that that needs to be

1 captured in a recommendation statement rather than a finding?
2 Val is nodding her head yes. Any other -- I see another
3 head nodding yes. I see a third head nodding yes. Thank you,
4 Val. Does anybody object to moving those two? And again, we
5 won't word smith them. I will word smith them to try to turn
6 them into recommendation statements later. I see another head
7 nodding yes.

8 So I will take those two bulleted sets of learnings
9 related to successful patient-centered primary care and
10 transform those into recommendations. And then moving on, we
11 have two recommendations, again, with a series of bullets
12 underneath. And one thing I wanted to point out -- I believe
13 I might have added this since after our teleconference, and at
14 least, the initial circulation of this draft to you all --
15 there used to be three bullets under our first recommendation,
16 and now the third bullet -- there are four now, and the third
17 bullet is new. And I wanted to make sure we captured the
18 importance of collaboration between any state government
19 programs or any other payer entity that might be interested in
20 initiating a medical home initiative with the primary care
21 clinicians will be responsible for implementing it. And so I
22 think that's new. But again, without going over these in any
23 detail, does anybody have any either questions, comments, or
24 requested changes? Pat?

25 COMMISSIONER BRANCO: In reviewing this on page two, the

1 bottom bullet.....

2 COMMISSIONER ERICKSON: Page two of the slide?

3 COMMISSIONER BRANCO: Yes. Right there. Go back one.
4 Oh, that's page two. The bottom bullet talks about that, the
5 patient's involvement in this, and that's lacking in the
6 recommendation to the Governor, that we have a discussion
7 about more empowerment of the patient, more education and
8 training of the -- training is a bad word. You don't train
9 patients. They help train you, but really, their active
10 involvement from an educated position. And unless I've read
11 it wrong, it just seems to be the one missing piece.

12 COMMISSIONER ERICKSON: And would it make sense to add it
13 to the list of bullets under the first recommendation of the
14 things we want the Governor and the Legislature to understand
15 as the importance of.....

16 COMMISSIONER BRANCO: Yes. I think it's well-written in
17 here.....

18 COMMISSIONER ERICKSON:patient engagement?

19 COMMISSIONER BRANCO:and would fit just perfectly
20 to raise the awareness of the Governor on that issue.

21 COMMISSIONER ERICKSON: Does anybody object to -- does
22 everybody understand what Pat is suggesting and does anybody
23 object? Okay. Any other questions or comments? Wes?

24 COMMISSIONER KELLER: Unless I'm missing something, on
25 the second bullet on the first page, on page two, actually, it

1 is, is there a way to add the words in there just to -- it
2 talks about the fact that evidence-based medicine may or can
3 reduce health care costs -- emphasize the fact that evidence
4 in a good system is changing fast? It's a dynamic process, so
5 the management of the data has to be dynamic, you know, just
6 to make the tie because I can see a potential here, you know,
7 where it wouldn't be a cost reduction at all, but it sure is a
8 valuable, obviously, approach. And maybe that's captured when
9 you get down in your -- under patient care, patient-centered
10 primary care, but it just seems like there ought to be a
11 reference to the fact that it's a -- the evidence is dynamic.
12 It's always being improved in a good system. Therefore, the
13 management, you know, of that data must be -- could be
14 expensive. I don't know. I'm struggling, but I'm trying to
15 get just the concept out there.

16 COMMISSIONER ERICKSON: I'm wondering, if I add a finding
17 related to the evolution in medicine and in patient needs, if
18 I could somehow capture your thought there. Yes, Larry?

19 COMMISSIONER STINSON: Evidence-based medicine, nobody
20 gets it right the first time, and as the additional evidence
21 comes in over months, over years, our practices will change.
22 I think that's kind of what Wes is addressing. And so
23 something along the lines about the dynamic nature of
24 evidence-based medicine, including the compilation and review
25 of the data, to guide us in the future is very important

1 because, if we start evidence-based medicine three years from
2 now, we will be doing things differently than what we're doing
3 now for sure.

4 COMMISSIONER ERICKSON: Well, a couple of comments. One,
5 this really was meant to be more -- this bullet was meant to
6 be more about the importance of managing care for patients
7 with complex health conditions. So it was more about care
8 management. I just threw the term evidence-based in, not to
9 relate it to evidence-based medicine directly, but to say any
10 care management practice should be based in evidence.

11 But I want to harken back to our discussion about
12 evidence-based medicine. The way I understand it is that it's
13 implicit in evidence-based medicine that knowledge is changing
14 and what evidence-based medicine is about is understanding
15 grades of evidence, the quality of the evidence as there are
16 new developments, new knowledges being created, that
17 physicians and others responsible for making clinical
18 decisions, including patients, understand the quality of the
19 evidence that's behind the particular approach to either
20 diagnosis or treatment. Wes? And then, is that right, Ward?

21 CHAIR HURLBURT: Go ahead, Wes.

22 COMMISSIONER KELLER: You know, I mean, that's exactly
23 right.....

24 COMMISSIONER ERICKSON: Uh-huh (affirmative).

25 COMMISSIONER KELLER:I mean, as far as our

1 understanding of it. I just wondered if the wording could
2 express that.

3 COMMISSIONER ERICKSON: Okay.

4 CHAIR HURLBURT: Yeah (affirmative). I think that's
5 right, but I'm also wondering, are we making this too
6 difficult? Because what we're talking about maybe at the core
7 -- is it that our recommendation is that the role of the
8 primary care physician, as that should function
9 idealistically, that we believe that should be at the center
10 of medical practice, that the center shouldn't be the
11 interventional cardiologist or the cardiothoracic surgeon.
12 People that Noah needs or that a primary care physician needs,
13 that we all need, that -- but in looking at the international
14 systems of care, one of the things that typifies other
15 countries where they spend far less than we do, but live
16 longer and don't have as many babies is the role of the
17 primary care physician is more central.

18 So we're saying that the primary care provider in Alaska
19 should really be more focal. To facilitate that, the
20 corollary to what we're saying -- and I think a part of the
21 recommendation is then some of the things that the primary
22 care physician does to facilitate that role need to be better
23 recognized in terms of reimbursement because many of the
24 things that are essential to that are not recognized for
25 reimbursement, and if you (indiscernible - voice lowered), you

1 do very well. If you do some of these other things, you may
2 get nothing on that. So is that really at the core of saying
3 that -- and then that has implications for the allocation of
4 physician specialties, where we should have more primary care
5 specialists, where that role really should be central. It
6 does have aspects to it in a word that got a lot of negative
7 connotations, like gatekeeper, but that also could be a very
8 positive concept, I think, and it also has to do with what do
9 your reimbursements support and foster. Is that kind of at
10 the core of what we're talking about?

11 COMMISSIONER ERICKSON: So, Ward, are you suggesting --
12 again, we're not going to word smith, but are you suggesting
13 that our recommendations need to be more succinct and more
14 focused?

15 CHAIR HURLBURT: Yes.

16 COMMISSIONER ERICKSON: So I'm just thinking, if we --
17 right now, we have two long sets of bullets. We just added
18 two additional. We're going to have four long sets of bullets
19 and recommendations. If I redraft recommendation statements
20 that are more succinct and more focused following your -- I
21 captured three, I think, and I could bring those back
22 tomorrow. We're going to have another two hours for
23 discussion tomorrow. So I could take a stab at doing that,
24 but now I'm wondering what we do with our four long sets of
25 bullets, whether we move them back to findings or if we just

1 have those three, shorter, more succinct recommendations up
2 front. Does anybody have a recommendation regarding what we
3 do with those recommendations? Did you have a thought, Ward,
4 as you were making your suggestion now that we get more
5 focused?

6 CHAIR HURLBURT: It seemed like we were getting broader
7 and broader afield, and Val tried to bring us back, and I
8 think, what's really at the core of what we're talking about?
9 That's where I was coming from. I think it's important to see
10 what other folks think. Val?

11 COMMISSIONER DAVIDSON: I love less is more. The
12 challenge with that is using fewer words really leaves open a
13 lot of room for interpretation, and I think we've been pretty
14 specific in our recommendations, and I would caution us
15 against being -- leaving anymore room for interpretation
16 because, I think, it took us a long time to get to where we
17 are, and I would hate to lose some of that whatever we're
18 going to call it, some of that oomph in shortening down a
19 recommendation that could be misconstrued in ways that are not
20 really our intent.

21 COMMISSIONER ERICKSON: Other thoughts?

22 COMMISSIONER DAVIS: Okay. I'll weigh in. I was just
23 reading back through this. It was a couple days ago when I
24 read it, but I think what we have here does kind of find a
25 really pretty effective middle ground between being succinct

1 and being broad enough to be specific. So I like what we've
2 gotten here for the recommendations and would suggest we adopt
3 them and go to the next one.

4 COMMISSIONER ERICKSON: Any other thoughts?

5 CHAIR HURLBURT: David, you've got a thought?

6 COMMISSIONER MORGAN: I have many thoughts, but it seems,
7 to me, that a lot of the issues are market issues, the economy
8 issues, and the recommendations are specific enough that, I
9 think, gets us to where we want to go. I think we should take
10 what we have and move on, and if we need to do some adjusting
11 once we get into the recommendations, if we have a
12 contradiction or these bullet points don't match up to the
13 recommendations, we can go back and fix them, but I think we
14 need to -- kind of like we need to move on so we've got a
15 document, a finished document. So I agree with my colleagues
16 over there that let's go.

17 COMMISSIONER LAUFER: Will we have an opportunity to
18 revisit this after, for example, we look at the Milliman data?

19 COMMISSIONER ERICKSON: We're going to have another two-
20 hour discussion session tomorrow and then we also will have --
21 and we can bring this back tomorrow, if you would like to do
22 that. We're also going to devote most of our October meeting
23 to a final work session before we release our Findings and
24 Recommendations as draft for public comment.

25 COMMISSIONER LAUFER: Thanks.

1 CHAIR HURLBURT: Is there a consensus around David's
2 suggestion then? Okay. Thank you.

3 COMMISSIONER ERICKSON: What I will do is bring back to
4 all of you tomorrow a revised document that will pull those
5 last two long sets of bullets from the Findings to the
6 Recommendations section. I'll add that third finding to the
7 first recommendation bullet, and also Ward, I will take a stab
8 at doing something in the next draft to emphasize in the
9 recommendations the important role that primary care does in
10 emphasizing how much more it could be doing in the health care
11 system overall and also the fact that that needs to be better
12 recognized through reimbursement. I'll try to emphasize that
13 more right up front in a first recommendation. Does that
14 sound like a good plan?

15 COMMISSIONER DAVIS: Yeah (affirmative), and I think
16 Ward's reference to other countries and the difference is also
17 a good point to, perhaps, include in that.

18 COMMISSIONER HIPPLER: Mr. Chairman, I have a question.
19 I'm getting a little confused. Are we done talking about
20 findings and now we're talking about recommendations or are we
21 done with both of those and we're moving on?

22 COMMISSIONER ERICKSON: Can I answer?

23 CHAIR HURLBURT: Go ahead.

24 COMMISSIONER ERICKSON: Yeah (affirmative). Just related
25 to the patient-centered primary care section, we're just

1 wrapping up both findings and recommendations; correct. Did
2 you have some thoughts related to.....

3 COMMISSIONER HIPPLER: I have several questions, but --
4 okay. Sorry to drag this out. Is our recommendation mainly
5 related to the state of Alaska, how it treats its own employee
6 and its employee health program?

7 CHAIR HURLBURT: No. It's beyond that. Basically, the
8 charge to the Commission related to accessibility,
9 affordability, quality of care for all Alaskans, and kind of
10 the issues that the nation is wrestling with, but in our
11 Alaskan context here of what's most appropriate. The
12 recommendations are going to both the Governor and to the
13 Legislature, since those are the entities that established the
14 Commission there. Obviously between the Legislature and the
15 Governor, they can't do everything that -- you know, we are
16 dominantly a private sector economy here. So the audience is
17 broader than that, but that's kind of the context for what
18 we're doing. I don't know if that helps, Allen.

19 COMMISSIONER ERICKSON: Allen, you have to use your mic.

20 COMMISSIONER HIPPLER: In our second recommendation where
21 we're discussing state investment, is that investment that we
22 are considering will be applied outside of the State's
23 employee health system?

24 COMMISSIONER ERICKSON: Yes.

25 CHAIR HURLBURT: Yes?

1 COMMISSIONER KELLER: Just for clarification, I want to
2 withdraw my statements. I spoke before my brain was fully
3 engaged, and you convinced me. This is -- you know, this is
4 not a statement on evidence-based medicine in the application
5 of this finding. So don't try to struggle with that in
6 rewording, unless you feel really inspired.

7 COMMISSIONER ERICKSON: Thank you, Wes.

8 COMMISSIONER MORGAN: Not to slow things down, but to
9 deal with the issue of investment. We have several sessions,
10 especially the Carolinas. Was it North Carolina? Yeah
11 (affirmative). Hey, I got something right, North Carolina's
12 set up of doing patient home process. We've actually looked
13 at three different models. I don't think we're going to
14 recommend this is one model. It's going to be more of these
15 are the different models and different choices. We just
16 needed to come up with some definitions to help everybody get
17 there, but I think what you'll see in each of those models
18 between Medicaid and Medicare and other state programs that
19 there would be, either through reimbursement or some grants or
20 some collaboration with insurance, the State health insurance
21 program, other payers, that there would be ways of helping to
22 mitigate and to bring resources there where it shows that it
23 makes patients healthier or delivers care faster, better, or
24 safer, and for our Chamber of Commerce friends, every once in
25 a while make people healthier. So costs may go down,

1 especially in the chronic arena.

2 So it's kind of three-dimensional. This stuff is not
3 easy, and I feel for your -- you need to ask a lot of
4 questions, and I think, even at breaks, you should corner some
5 of us because you're kind of starting at a disadvantage in
6 that we've been kind of chugging through this stuff for a
7 year, and you need a little time, and you should have a lot of
8 questions. If you didn't have a lot of questions, I think all
9 of us at this table would be a little concerned. So ask away
10 and just, no matter how strange your question may be, do not
11 feel inhibited. I don't think you'd be here if you were
12 inhibited anyway. But I think there is going to be a lot of
13 these choices. We want a lot of choice, but there is also
14 going to have to be some transition to get there. There are
15 going to be a lot of places where there will be money
16 available to help us do that for all the sectors that want to
17 engage. Is that close?

18 COMMISSIONER ERICKSON: Yeah (affirmative). Absolutely.
19 And I want to ditto Dave's comments. And Allen, actually, you
20 could be an important test for us. If you don't feel the
21 findings -- if you're looking at this recommendation that the
22 State make an investment and our findings, I was assuming,
23 were supporting the case that investing and strengthening
24 primary care -- what we learned is that has demonstrated
25 actually savings overall in the health care system. Both

1 savings in the health care system -- it makes care overall and
2 per capita cheaper by putting more money into primary care and
3 patient-centered primary care and doing it right, and it also
4 improves health. And so I mean, that's kind of the bottom
5 line of our -- and so if we're getting too wordy with all of
6 our finding statements, and I think, to Ward's point, that he
7 was concerned that we were maybe losing the meat of what our
8 recommendation should be, I wonder if we've lost the meat of
9 what our findings should be as well, if that's not clear. So
10 was that where your question was coming from or am I reading
11 too much into your question?

12 COMMISSIONER HIPPLER: I was confused as to whether or
13 not this specific recommendation was directed toward the
14 employees of the State and their health plan as opposed to the
15 entire health care system in the state of Alaska. You're
16 telling me these recommendations will be supporting the entire
17 health care system in the state of Alaska, which, if this
18 program is faster, better, and safer and saves money, I don't
19 understand why the existing providers are not already
20 employing this program of their own volition.

21 COMMISSIONER ERICKSON: Because the way the reimbursement
22 system is structured doesn't support them to do that.

23 CHAIR HURLBURT: The State, as a buyer of health care
24 services, whether it's Medicaid employees, retirees, workman's
25 comp, corrections, and so on, is a big factor in the market,

1 and I think, in tomorrow's session with Commissioner Hultberg
2 and Commissioner Streur, you will hear about some interest in
3 looking at that.

4 One of the things that you have been blessed to be free
5 from by just joining is my mantra that we're talking about
6 costs, costs, costs. Nationally, we're at 18% of GDP. In
7 Alaska, we're higher than that. And so we have to do this in
8 the context of containing costs, but hopefully in a way that
9 improves the quality of care. It's not slash-and-burn. So
10 when we use a word, like investment, as, say, directed to the
11 House of Representatives, it is not investment spending more
12 money and enlarging this pie, but looking at this huge pot of
13 dollars and how we can we more effectively spend our money.

14 Back when the Commission first started two-and-a-half
15 years ago, I think the very first meeting -- and that was
16 before I came onboard -- talked about and Representative
17 Keller raised the issue of evidence-based medicine, but
18 basically, 35%-40% of medical care is probably not really
19 supported by high grade evidence as being effective. And when
20 you have two-and-three-quarters trillion dollars nationally,
21 40% of that is real dollars, that there is a lot of money in
22 the health care sector and so the thrust of talking about
23 focusing on patient-centered primary care, the role of the
24 physician as the educator in that, working collaboratively
25 with the patient and deciding what do you. If you have a

1 prostate cancer, do you have a radical prostatectomy? Do you
2 have a chemical or a physical castration? Do you freeze the
3 drug? That decision is made collaboratively and that's a part
4 of what we're talking about, but the context of investment is
5 not in a bigger pie, but how do we take this pie? And
6 hopefully, it can become a little bit smaller because what we
7 spend is a tax and takes money from education or roads or what
8 not. Everybody else here has heard me say that a lot and so
9 you have been spared that, I guess, but that's, I think, the
10 context that we're talking in, Allen, when we talk about that.

11 COMMISSIONER ERICKSON: Are we ready to move on to
12 trauma? I'm not going to review the findings here with
13 everybody. You can see them on your page. Just the
14 significance of the burden of trauma on our population, the
15 importance of a strong trauma system, what a strong trauma
16 system is, the commitment that has already been demonstrated
17 in our state both by state government, by the Department of
18 Health and Social Services specifically, the state
19 Legislature, but also the health care community, particularly
20 all of the hospitals that have been engaged in stepping up
21 their trauma capacity and becoming trauma centers are all
22 captured in those findings. So does anybody have any
23 questions or comments, suggested changes -- yes, Val -- to the
24 Findings? Hearing none -- I didn't miss any important concept
25 in the Findings? Okay. Moving on to Recommendations.

1 COMMISSIONER DAVIDSON: I would recommend that the third
2 bullet that starts "a strong trauma system" be incorporated
3 into the recommendation.

4 COMMISSIONER ERICKSON: Oh, my goodness. What did I do?

5 COMMISSIONER DAVIDSON: So that piece and incorporate
6 that maybe as a subcategory under the recommendation.

7 COMMISSIONER ERICKSON: So Val is proposing that, on
8 slide ten, the finding that defines what a strong trauma
9 system is with all of these bullets be moved to our
10 recommendation. Does anybody have any questions about her
11 recommendation, and does anybody have an objection to that
12 recommendation?

13 COMMISSIONER DAVIS: Val, do you mind saying a little
14 more as to why, please?

15 COMMISSIONER DAVIDSON: Sure. While I think it would be
16 an admirable goal for everyone to read the American College of
17 Surgeons Committee on Trauma Recommendations, I'm just not
18 confident that that's going to happen and so I'd like a more
19 robust description of what those recommendations are.

20 COMMISSIONER DAVIS: Thank you. So you are assuming then
21 slide ten is the gist of those recommendations, and should we
22 put it there so it's obvious rather than by reference.

23 COMMISSIONER DAVIDSON: Yeah (affirmative), and I guess I
24 like what's in that bullet, in those bullets. So I think that
25 we should describe what it is that we want rather than refer

1 to a separate document.

2 COMMISSIONER ERICKSON: I see a couple heads nodding.
3 Does anybody object with that suggestion? Hearing none, let's
4 move on to immunizations. I've added a couple lengthy finding
5 statements there, actually several lengthy finding statements
6 that probably need to be cleaned up a bit, but just trying to
7 capture the significance of the developments of vaccine in
8 eliminating, in some cases, or greatly controlling, especially
9 diseases of childhood, but also other conditions that affect
10 other age groups, but then moving on. So does anybody have
11 anything? Do you want to take a minute to look over those
12 finding statements in your slide handout to see if there is an
13 important concept that's missed there? Yeah (affirmative)?

14 COMMISSIONER LAUFER: With, I think, a decline in the
15 immunization rates, a big issue there is education and
16 misinformation of the public and that is an area where
17 something specific could be done to improve that. There is a
18 lot of just flat out baloney available to people cloaked as
19 real information.

20 COMMISSIONER ERICKSON: Are you suggesting that we should
21 have a recommendation related to education or do you want me
22 to strengthen -- I'm looking at.....

23 COMMISSIONER LAUFER: I think the second -- well, where
24 it says "parents must recognize vaccines," I don't know that
25 you can say a parent just do anything, but we could provide

1 better education.

2 COMMISSIONER ERICKSON: So you're suggesting that I could
3 reword that bullet. Very good. I will do that. Any other
4 questions, comments, or suggestions about the immunization
5 findings?

6 COMMISSIONER HIPPLER: I have one question. The
7 statistics for rate of immunization completion, if a child has
8 missed any immunization, for example, even the new
9 immunization against cervical cancer, is that considered an
10 incomplete completion and takes down that percentage rate?

11 CHAIR HURLBURT: There are multiple ways of measuring
12 this, and I think what Noah suggested, I concur, that it's
13 misinformation that is driving a lot of the low immunization
14 rates, but it has become more complex. I think it's, like, 17
15 now, is it, by 35 months or two years of age that a kid is
16 supposed to have -- and it's costly. It's about \$1,400-\$1,500
17 just for the vaccine cost, which has gone up. Say ten years
18 ago, it was maybe \$400. And the meningococcal vaccine and the
19 HPV have been cost-effective drivers. So, yes.

20 So what we try to do is look at the comparisons because
21 there is all kinds of data and some of the data includes all
22 of the recommended vaccines, including the HPV, and some of it
23 measures the specific ones. We've had a universal vaccine
24 program where the vaccine has been provided for all children
25 at no cost with federal money and that's going away.

1 Historically, Alaska got well more than it's share of that
2 money, thanks, specifically, to Senator Stevens, and that
3 started the change in 2009. And we're being treated fairly,
4 but we're still, over the next two or three years, going to
5 lose money. We are hoping that we can get some state support
6 for that, and we're actually, in the request specifically,
7 excluding because they're costly and we're trying to get a
8 dollar amount that may fly, but excluding the meningococcal
9 vaccine because the cost-benefit ratio is about -- is not
10 nearly as strong as it is for most vaccines, and likewise,
11 excluding the HPV because of the controversies relating to
12 giving that vaccine, and not that it's not effective there.
13 Doing that brings the cost way down. That may or may not go,
14 but we're trying to make it as easy and trying to make as much
15 support as we can, also hoping that we can get support for flu
16 vaccine for the over 65s, which is the group that experiences
17 the most mortality related to seasonal flu vaccine. Kind of a
18 long answer, but it really is very complicated. So when you
19 see the statistics, it may reflect various things, but however
20 you look at it, we're not doing well in Alaska, looking at the
21 19 to 35-month old group.

22 COMMISSIONER ERICKSON: To his specific question though,
23 HPV is not included in the schedule for kids 19 to 35 months,
24 is it, or is it now?

25 CHAIR HURLBURT: No. It's not.

1 COMMISSIONER ERICKSON: It's not. It's not. So it's not
2 -- in that particular statistic, Allen, it is not included.

3 COMMISSIONER HIPPLER: Thank you.

4 COMMISSIONER ERICKSON: Other questions or comments about
5 the immunization finding statements? Move on to the
6 recommendation? And this hasn't changed since the last draft
7 that you saw. Yes, Jeff?

8 COMMISSIONER DAVIS: So Ward, it sounds like there is a
9 specific recommendation that's being put out maybe by the
10 Department around?

11 CHAIR HURLBURT: I don't know. I was maybe saying a
12 little more than I should have said, but it's okay because, I
13 think, it's important looking forward and talking about
14 looking for the 2013 budget, but budgets are tight. The
15 Department of Health and Social Services in Washington, which
16 is Medicaid, basic health plan, the state employees have
17 enrolled into that now. They have lost 13% of their staff and
18 more than that in their budget. We've been protected here.
19 So times are going to get tight and (indiscernible - voice
20 lowered), but it is an initiative that we put forward, hoping
21 that we could gather some support for 2013 because, I think,
22 there has been -- just from the questions that we've had --
23 when it was announced that we couldn't provide free vaccine,
24 like, for seniors for flu vaccine and that only the
25 administrative costs would be charged, we had a fair number of

1 inquiries coming from the Legislature. So I think a lot of
2 our legislators are concerned that folks who have been getting
3 vaccine will no longer be able to get it at no cost.

4 COMMISSIONER DAVIS: The reason I ask is this strikes me
5 as a spot where we have a very high level recommendation, and
6 if I'm Representative Keller or one of his colleagues and I'm
7 supposed to give priority to it, but what does that mean that,
8 perhaps, either reference to someplace where there is some
9 specificity or some greater specificity might be helpful and
10 useful and more effective here.

11 COMMISSIONER ERICKSON: Ward, do you think we should try
12 to make this recommendation more specific, not as specific as
13 noting a particular.....

14 CHAIR HURLBURT: Yeah (affirmative). That's what I
15 think, but I would like to hear what other people think about
16 it.

17 COMMISSIONER LAUFER: From sort of a doctor historical
18 perspective after potable water and sewage treatment,
19 immunizations were the next great leap in, you know, human
20 health care. My understanding is that, in Washington, the
21 State stopped funding immunizations for children, and is there
22 a federally-mandated requirement?

23 CHAIR HURLBURT: There is not. The State stopped
24 funding, and what happened in Washington where they salvaged a
25 lot of the program, it was by the health insurance plans

1 coming in, collaborating with the State, working with the
2 State, even where the state budget was being significantly
3 cut, and the health plans said, you know, this is good
4 business for us to do it because of the cost-benefit ratio.
5 And so the funding that had come through the federal dollars
6 for the universal vaccine program was, to a significant
7 extent, replaced with other fundings, and I don't know what
8 the percentage is. I don't know, Jeff, if you know more about
9 that than I do.

10 COMMISSIONER LAUFER: I'm not sure it's fair to Jeff to
11 recommend that the health plans take over our immunization
12 program, but that's a great idea.

13 CHAIR HURLBURT: Well, the -- like, Medicare now covers
14 more of the preventive services than they did. I stopped at
15 Carrs on my way home when I got my shot last night. That's
16 why I was bragging this morning. But I just showed them my
17 Medicare card, and it didn't cost me a penny there. So some
18 of the coverages do provide that. Yeah (affirmative).

19 COMMISSIONER LAUFER: On a tiny little insight, you know,
20 you got your immunization at Carrs; you can get it any big box
21 store with muscle. We don't have our immunizations yet and
22 that tells you a little bit about how the system works, but
23 we're not Walmart.

24 CHAIR HURLBURT: So do we want a specific recommendation
25 on this? Pat?

1 COMMISSIONER BRANCO: I think it's imperative that we do
2 because this recommendation comes out sounding pretty bland.
3 We want to improve immunization rates. It's, like, gee, I
4 wish it was sunny tomorrow. It's a little bit weak because
5 the reference that we're 49th out of 50 states in this country
6 is appalling. And so if we don't add a piece of punch right
7 here, I think it's too bland and it'll miss the attention of
8 our representatives.

9 COMMISSIONER KELLER: You may be right, but I think
10 you've got to remember the credibility of the Health
11 Commission. I think it'll be paid attention to for that
12 reason, and the findings will be referenced for that reason.
13 So there is -- like Val, I think, said earlier, there is a lot
14 to be said for a concise approach.

15 Not only that, but our work isn't over once this is
16 recommended. You know, I mean, it really isn't. I mean, the
17 Health Commission needs to be interactive and to emphasize the
18 points (indiscernible - voice trailed off).

19 COMMISSIONER BRANCO: So to the point earlier, even if we
20 have a reference just pointing back to the findings would be
21 adequate. The findings are there. They're part of the
22 recommendation.

23 COMMISSIONER ERICKSON: So we don't have any specific
24 changes recommended, and Representative Keller was advising
25 that, perhaps, it's better to leave it a little more general.

1 Yes, Val?

2 COMMISSIONER DAVIDSON: I was going to recommend a
3 specific edit in, unfortunately, the opposite direction. So
4 if I may disagree, I would recommend that we change this to
5 read, "the Alaska Health Care Commission recommends the
6 Governor and the Legislature to fund immunizations to a level
7 adequate to improve immunization rates to protect Alaskans
8 from serious preventable diseases and their complications."

9 So you have a little bit of wiggle room by not defining
10 improve, but it gives a little more punch to, if you really
11 support it, then support it in the way that counts the most,
12 which is making it affordable to folks.

13 COMMISSIONER KELLER: This shows, probably, cynicism with
14 time and everything, but there is a tendency to pay less
15 attention when it's an advocacy for more dollars than for good
16 health, and like Dr. Stinson just pointed to me here a little
17 bit ago, immunization has done more -- you know, can be shown
18 to have done more for more for better health, and in many,
19 many places, you know, it's very -- well, you know, it stands
20 on its own. And if it sounds like that the Health Commission
21 is going and continually saying more money, fund this, pay for
22 this, pay for this, pay for this, I would propose that that
23 probably has less weight, for what it's worth.

24 COMMISSIONER ERICKSON: So hearing that point and
25 counterpoint, Val, do you feel strongly enough, understanding

1 this is still draft for a while yet, that you would like to
2 make a motion to change the draft and see what the will of the
3 group is at this point in the process?

4 COMMISSIONER DAVIDSON: I think, at this point, I'm happy
5 to pretend that we're not asking for more money to fund
6 immunizations.

7 COMMISSIONER ERICKSON: Very good. Thank you. Any other
8 questions, comments, or discussion around the immunization
9 recommendation?

10 Moving on to Overweight and Obesity. Again, the finding
11 statements could probably use significant word smithing and
12 cleaning up, but just tried to capture some of the main points
13 around the significance of overweight and obesity as a public
14 health challenge today, the burden in terms of premature death
15 and costs, concern about the prevalence of overweight and
16 obesity amongst our children, and then the recommendation that
17 we had drafted a month or more ago related to overweight and
18 obesity:

19 "The Commission recommends the Governor and Legislature
20 recognize overweight and obesity as a worsening multi-decade
21 public health crisis and supports state program efforts that
22 initially target children and young people related to diet and
23 physical activity and also use the media to raise public
24 awareness of overweight and obesity and the grave risks of
25 these conditions."

1 It just occurred to me, that folks on the phone haven't
2 been able to follow what we're talking about in terms of our
3 recommendation statements here, so I thought I'd read that
4 one. Yes, Linda?

5 COMMISSIONER HALL: In the finding statement, the third
6 bullet -- maybe, if I pull it over; part of it has to do with
7 my height. Valerie said we need booster chairs.

8 The third bullet under the findings, Direct Medical
9 Spending, blah-blah-blah, is this direct medical spending
10 related to obesity and overweight?

11 COMMISSIONER ERICKSON: Yes. It is, but.....

12 COMMISSIONER HALL: I think it should somehow.

13 COMMISSIONER ERICKSON: It will. It will say that.
14 Thank you.

15 CHAIR HURLBURT: It has now surpassed that related to
16 tobacco.

17 COMMISSIONER HIPPLER: Mr. Chairman, I apologize for my
18 lack of medical background. I need to ask a basic question.
19 In the findings, it's referring to obesity as a disease. Is
20 obesity a disease?

21 CHAIR HURLBURT: Dr. Laufer? It's certainly a morbid
22 condition.

23 COMMISSIONER LAUFER: I'd say it's both a disease and a
24 risk factor. There certainly are people who are obese who
25 don't get diabetes and degenerative disease and all that, you

1 know, joint disease and hypertension and all that and sleep
2 apnea and all the related issues, but even if you didn't have
3 any of those, there is morbidity associated with being obese.
4 It's not a lot of fun to pack around an extra 100 or 30 pounds
5 or whatever. It's a good question though.

6 CHAIR HURLBURT: We have seen, in Alaska and nationally,
7 the percentages of young people, children, and adults
8 overweight and obese, as defined by body mass index,
9 dramatically increasing, and along with that, the CDC now
10 projects that girl babies currently being born in this country
11 have a 38% risk of being diabetic as adults. And if you're
12 38% -- where currently, it's about 6% to 8% and going up.
13 That has huge cost, huge life expectancy implications. If you
14 are a woman at age 40 with diabetes, most of which is going to
15 be overweight and obesity related, your life expectancy at age
16 40 is reduced by 14 years on the average. If you're male,
17 it's reduced by 11 years. About 34% of boy babies being born
18 now are projected to become diabetic and that's just one of
19 the complications. I believe it is clearly the predominant
20 public health challenge to our nation and to our state here.
21 If, at the break, you want to have an avalanche of other
22 shocking information, I have it ready. But it's something
23 we've talked about, but it is a huge problem to our society,
24 to our economy, to the health of all Alaskans.

25 COMMISSIONER MORGAN: If this helps any, there are

1 diagnostic codes in the coding system. So it is determined in
2 ICD-9 and it's actually expanded in 10 that it is a diagnostic
3 code that has procedures and information attached to it, so it
4 can be assigned as. So from a technical coding standpoint,
5 yeah (affirmative), it's a disease. It can be diagnosed and
6 given a code number.

7 COMMISSIONER KELLER: It's really another topic. On the
8 recommendation, I'm struggling with the wording there. After
9 that line four, after the comma, between that comma and the
10 one on line six or whatever it is, "and support state program
11 efforts that initially target children and people related to
12 diet and physical activity," I think that's a little too
13 broad, you know. I mean, in my mind, I'd like to see it
14 qualified some because I don't think -- are we recommending to
15 the Legislature that we do all, you know, support any program
16 that comes along and just what does it mean to target children
17 and young people related to diet and physical activity? You
18 know, maybe just adding a word, you know, promising programs
19 or programs that show some hope of reducing obesity and
20 overweight in children. In other words, I'm all for the
21 statement, but it just seems a little bit -- I think we lose
22 credibility if we say more than we mean to say, and I think
23 this says support every program that comes along, you know.
24 Let's target overweight and obesity on kids, and I think that
25 loses credibility.

1 COMMISSIONER ERICKSON: If I add some wording so that
2 it's related to best practices, would that make you feel
3 better? Yeah (affirmative).

4 CHAIR HURLBURT: I think that's a good point.

5 COMMISSIONER HIPPLER: Mr. Chairman, are there any
6 existing or past state programs that have had a positive
7 impact on obesity, just so you could mention them so I know
8 what we have in mind when we're saying this?

9 CHAIR HURLBURT: Yes. The MatSu School District and the
10 (indiscernible - voice lowered) Council, I think, took this
11 on. They, along with some other school districts, got sugar-
12 sweetened beverages out of the schools. They increased their
13 physical education activity, their physical activity at recess
14 times out of school. They improved the school diet, and one
15 point doesn't make a trend, but it begins a trend. The data
16 that came out last November showed that, over the last eight
17 years or so, the body mass index for the school children in
18 MatSu has trended down. That's extraordinary, what's
19 happening in the country. Anchorage, where Carol Comeau has
20 been a real strong supporter of the efforts also, has kind of
21 stabilized on that curve. So we're seeing some successes
22 there.

23 The efforts that we've had -- and so far, there has been
24 kind of ad hoc funding. There was some capital funding that
25 came from the Legislature last year, and the Governor allowed

1 part of that to stand, \$430,000, for efforts, and we had a
2 competitive bid from the CHIPRA, the Childhood Self-
3 Improvement Program, an award that we got of \$500,000, we're
4 putting that into some media efforts, and we're also putting
5 it into working with the schools. There has been a proposal
6 for a competitive award in the school districts with, perhaps,
7 the seven districts around the state with \$150,000 or so that
8 could go in and do the kinds of the things that MatSu has been
9 able to do successfully.

10 There are a number of anecdotes. For example, in the
11 school cafeterias around the country, there is concern that
12 the Fritos and the potato chips and so on sell really well and
13 the fresh fruit doesn't. The New York City School District
14 wondered how much would they have to raise the price of the
15 chips and reduce the price of fruit to get it to sell. They
16 didn't change the price at all. They just did marketing.
17 They took the apples and so on, and they put it out, and they
18 displayed it very attractively, and they took the chips and
19 they put them back where it was hard to find, and they had a
20 54% change. So I think that, as a country, I'd have to say we
21 don't know a lot. We'll probably make some mistakes in
22 addressing. The anti-tobacco efforts have taken decades, but
23 we have had a real societal change from where we were when I
24 was young and growing up, and it's probably going to take
25 decades on this, but there are successes that we can look at

1 it. The physical education and the physical activities have
2 been reduced in schools, partly in reaction to our not real
3 good results on the reading, writing, arithmetic kinds of
4 things, our math scores and so on, to try to have time for the
5 basic skills. Well actually, we have pretty good data that
6 shows that, if kids are active and have physical education,
7 their academic scores are better on the average there. So we
8 know some things. We'll probably make some mistakes along the
9 way, but it's such an urgent issue that we really need to
10 engage in the process and change our societal norms. David?

11 COMMISSIONER MORGAN: Yeah (affirmative). The
12 municipality of Anchorage, through their Health Commission
13 over the last four years, has developed an overall plan
14 working with the school district, and this summer, they
15 basically, with the Parks and Rec foundation that they formed
16 -- Parks and Rec Department, the Health Commission, and the
17 Health Department -- has revamped, fixed up, made it a much
18 easier access to all the parks, down to the smallest in the
19 whole city, and more than half the labor to do that was
20 provided by the volunteers in the community.

21 I was at one at Rogers Park. There was 70 people there,
22 a third of them kids, and they got out there and helped fix
23 the park. For the first time, some of them didn't know they
24 had a park, even though they might have been a neighbor to the
25 park. And also developing programs after school and doing

1 stuff, but more importantly, the Municipality, with the School
2 District, has an obesity plan that encompasses the whole --
3 all the departments. It doesn't make anybody do anything. It
4 just --when you do stuff, try to make it accessible, market
5 it, and tell people about it.

6 So there is a lot of stuff that you can do that doesn't
7 take a humongous amount of money. You've just got to get
8 everybody with the same concept and make it accessible and so
9 people know that it's accessible. And if our Colonel friend
10 was here, he would tell you that they're having a really hard
11 time getting enough troops at the basic level because none of
12 them can pass the physical or the PT tests to be a private in
13 the United States Army or join one of the other services
14 because they're way overweight and can't cut it. He could
15 probably hit you with the same kind of statistics.

16 COMMISSIONER ERICKSON: Well, it's.....

17 CHAIR HURLBURT: Yeah (affirmative). It's 25% of
18 potential enlistees.

19 COMMISSIONER ERICKSON: No. I think it's 30% now.

20 CHAIR HURLBURT: Is it up to 30?

21 COMMISSIONER ERICKSON: Uh-huh (affirmative).

22 CHAIR HURLBURT: Yeah (affirmative), are disqualified
23 because of being overweight or obese.

24 COMMISSIONER ERICKSON: Any other recommended changes to
25 the draft recommendation? Good. Okay. Let's move on to

1 Behavioral Health, and I don't want to dwell at all on the
2 findings because it's still a pretty rough draft, but just
3 again, trying to capture some of the main points about the
4 burden of behavioral health conditions in our population. The
5 last couple bullets, especially, really need to be cleaned up,
6 but I tried to have a transition to the significance, the
7 importance of screening and also behavioral health and primary
8 care integration. Those really need to be cleaned up. If
9 there are any main points that you want to make sure are
10 captured in the findings, just let me know and I can go back
11 and clean up that rough draft and add anything more that you
12 want added there, but the two recommendation statements are --
13 there are no changes to the last draft that was circulated
14 after our teleconference.

15 While you're looking at the findings and thinking if
16 there is a concept you want to make sure is added there, just
17 for the sake of the folks on the phone, maybe I'll read
18 quickly the two recommendation statements:

19 "The Alaska Health Care Commission recommends the
20 Governor and the Legislature support efforts to foster
21 development of patient-centered primary care models in Alaska
22 that 1) integrate behavioral health services with primary
23 physical health care services in common settings."

24 And we're trying to get the concept that integration
25 doesn't have to happen in the primary medical clinic. For

1 certain populations, it might be appropriate to bring the
2 primary physical health care services into a behavioral health
3 setting.

4 "And 2) include screening for the patient population
5 using evidence-based tools to screen for a history of adverse
6 childhood events, substance abuse, and depression."

7 So that's our first recommendation. The second
8 recommendation is that,

9 "The Alaska Health Care Commission recommends the
10 Department of Health and Social Services develop and the
11 Governor and Legislature support new payment methodologies for
12 state supported behavioral health services -- that's for
13 services already supported by state government -- to
14 facilitate integration of primary physical health care
15 services with behavioral health care services in appropriate
16 common settings."

17 Any questions, comments, suggestions? Val?

18 COMMISSIONER DAVIDSON: I think I agree with the second
19 bullet, except for your caveat that it's currently state
20 supported behavioral health services because, I think, given
21 our need of behavioral health services in Alaska and our unmet
22 need for substance abuse programs, I would hate to limit our
23 recommendations to those that already have it and that's not
24 what I read this to mean.

25 COMMISSIONER ERICKSON: I misspoke. I don't think it

1 implies, and it wasn't meant to imply, current levels of
2 funding, but these are programs that are any program supported
3 by state funds, current or future.

4 COMMISSIONER HIPPLER: Mr. Chairman?

5 COMMISSIONER ERICKSON: Allen?

6 COMMISSIONER HIPPLER: In the first bullet point, there
7 is a recommendation that we include screening for the patient
8 population using evidence-based tools to screen for these
9 behavioral health issues. Does this mean that you're
10 recommending that private -- or excuse me, not private
11 practice -- general practitioners screen all of their patients
12 for this? Can you walk me through what this means? Thank
13 you, sir.

14 CHAIR HURLBURT: Yes. It does. It's a recommendation
15 that that be incorporated as a part of practice. There was --
16 it was very well done -- an interesting study that came out of
17 the Kaiser organization in looking at where this is done, that
18 it's been very effective in addressing the related subsequent
19 morbidities to these things, and I would suspect that, if it's
20 not 3 o'clock in the morning, it's what Noah does there in
21 kind of an ideal kind of practice, that he practices there.
22 So it is a recommendation that that happen. There is
23 certainly no power with a private practitioner to make that
24 happen, but since we are talking about all Alaskans, it is a
25 recommendation. Noah, did you have a comment?

1 COMMISSIONER LAUFER: Yeah (affirmative), certainly that
2 there is tremendous (indiscernible - voice lowered) here where
3 all these primary care docs are always accused of not doing
4 this enough and that probably is true. More true than that is
5 the documentation of it because everyone has a wish list of
6 what we should be screening for. You know, I'm supposed to
7 screen for ED, which is erectile dysfunction, but you know, I
8 have to depend on the patient to bring things up also. I
9 think there is some teeth in the meaningful use
10 recommendations that depression is screened for and that that
11 is documented. But again, if you want a doc who is, you know,
12 always available and working 18 hours and doing all this
13 stuff, notes used to not exist or be on a, you know, card
14 catalog thing that said, you know, March '67 pneumonia and
15 that was it, and the requirements for documentation for us are
16 unbelievable now. They are deeply cutting into productivity,
17 and this is one more thing, you know. How do you do it? Do
18 you say we recommend that you recognize these things or that
19 you fill out this additional form that documents that it was
20 asked? It cuts into the actual caring.

21 COMMISSIONER HIPPLER: I think every recommendation or
22 mandate for an increase in a type of service directly goes
23 into cost. Maybe you don't notice it one day, but you'll
24 notice it the next. If a general practitioner really did
25 screen every single one of his patients for these issues,

1 maybe, over the course of a week, you would see one less
2 patient. Does that sound reasonable? I'm concerned about
3 this recommendation.

4 CHAIR HURLBURT: Val?

5 COMMISSIONER DAVIDSON: Well, the question is really, how
6 are you going to see that person? If that means that that
7 person gets a behavioral health referral and they get the
8 services that they need, then perhaps you're not seeing them
9 later as a patient from a failed suicide attempt.

10 COMMISSIONER KELLER: I was -- you know, along the same
11 lines, in the second bullet under this recommendation, it's
12 asking the Department to come up with exploring new payment
13 methodologies and maybe just a reference here ought to be to,
14 you know, specify that that is to include the provider in that
15 payment methodology. In other words, do we really want to say
16 that Health and Social Services come up with this, you know,
17 or are we just going to assume that they're going to take into
18 account the needs of the providers, you know, and maybe we
19 should throw something in there on that.

20 COMMISSIONER ERICKSON: Wes, I just wanted to clarify,
21 you're suggesting that we add a statement that providers be
22 involved in the development of the new payment methodologies?

23 COMMISSIONER KELLER: Yeah (affirmative). You are way
24 better at word smithing than I am, but what I would do is,
25 where it says support new payment methodologies -- no,

1 development. There we go. Develop new payment methodologies
2 with the input of the -- with input from health care
3 providers.

4 COMMISSIONER ERICKSON: Thank you.

5 CHAIR HURLBURT: Any other comments on that? David?

6 COMMISSIONER MORGAN: I think what I'm going to do is --
7 I'm sure we'll have some comments in the comment period
8 because I know we have some Mental Health Trust people here.
9 I know, institutionally, the VA system, the Indian Health
10 system, and the Community Health Center system probably do
11 more types of that screening than other primary care docs or
12 nurse practitioners. I think -- I thought it was a standard
13 evaluation or a couple of questions whenever you visit your
14 doctor. It's now got me concerned that, when I visit my
15 physician twice a year, he always asks me those types of
16 questions. Now I'm becoming, you know, am I being singled out
17 for something? But I think it happens more than we think. I
18 think, especially on the integrated systems, it is sort of
19 built in, even down to the CHAP level, I think -- Val probably
20 could answer that better -- and especially in a VA military
21 system, the community health center. I know a lot of the
22 integrated systems that they are now going through a process
23 of integrating behavioral and mental health services into the
24 primary care system. It will be interesting to hear from the
25 physician community. I just -- you know, our family has been

1 going -- I just have to go by my own experience. We've been
2 seeing a primary care physician since we got to Alaska in
3 1982, and he seems to know when something's not right when he
4 talks to one of us. I don't know how you equate that as a
5 physician, I guess, you know, vibes or something. I think it
6 does happen on the primary care or in the practice, and it's
7 not necessarily formal, but a physician usually can pick up
8 when something ain't jibing, but I do think we need to address
9 it, but I think it will be interesting to hear comments, and I
10 am going to -- when our primary care person -- we usually have
11 a couple of people here in the afternoon. We may send out an
12 email blast to all the community health centers and just say
13 hey, here's a recommendation; what are we doing? I think
14 we're doing it a lot, but I'm kind of -- this is the one area
15 where we probably need to listen to the physician community
16 and the Mental Health Trust and the Behavioral Director, you
17 know, just hear their input, but it'll be interesting because
18 we have a few physicians as part of the Commission. I'd like
19 to hear what they -- is Dr. Baskus (ph) right, I need some
20 help here a little bit, or am I getting close?

21 COMMISSIONER ERICKSON: Larry?

22 COMMISSIONER STINSON: As part of pain management, we
23 routinely screen for these because it's intimately associated
24 between pain and depression and other mental health disorders.
25 The problems that we've had is that often the people who you

1 know have the worst problems are exactly the ones who will not
2 fill it out, refuse to fill it out, and refuse to see
3 somebody, and it usually takes coaxing over weeks, months,
4 establishing a good relationship. And so the people who do
5 fill it out, you have great data where, boy, it looks like
6 everybody is doing pretty well, and the ones that leave it
7 blank are the ones you wind up spending a lot more time in
8 your office talking with.

9 COMMISSIONER LAUFER: Real quick, this is Noah Laufer.
10 I'm a family doc, and one of the reasons I would never do pain
11 management is the heavy psychiatric burden because it's a
12 purely subjective experience and terribly difficult, but we do
13 screen for it, and there is, whatever, the vibe. And then
14 frequently, I just say, do you think you're depressed? Are
15 you suicidal or homicidal, you know?

16 The frustration, for us, is getting access to a
17 psychiatric or a psychologist or somebody in the behavioral
18 health field when we know we need it. That's the problem, and
19 I believe that that's a question purely of reimbursement. You
20 know, if someone is affluent and can afford \$400 an hour or
21 whatever, then they can get care. If you're really in
22 trouble, you can get institutionalized, but there's a huge
23 middle ground, and particularly with substance abuse. That's
24 one of the reasons I, you know, would consider going to a
25 system like the VA or the Native system or the North Carolina

1 system. And actually, Jeff and I talked about ways to
2 integrate behavioral health into private primary care
3 practice. You know, when I talk to my partners, that is one
4 of the things that gets their eyes winking, you know.
5 Really, I can just send them down the hall to, you know -- we
6 would all love that.

7 COMMISSIONER STINSON: I totally agree with Noah. That
8 is a huge roadblock. We have to call people and beg. And if
9 they're Medicare, I have to beg them, and we try to spread it
10 around and try to get people in, and it is -- if they are
11 really bad, you can get them institutionalized. If they have
12 good insurance and are more anxious, then everybody in town
13 wants to see them, and they have good outpatient practices.
14 If they are Medicare or Medicaid, they're going to go on lists
15 of waiting for months or longer. You really worry about these
16 people, and I agree with Noah. It's draining, and it would be
17 wonderful to have access to mental health benefits in town
18 somehow for the people who need it the most who are also the
19 ones who can afford it the least.

20 COMMISSIONER LAUFER: I know anecdotes aren't fair, but
21 they're powerful. I saw someone recently as a brand new
22 patient who, unbelievably, was insured and just suffered a
23 probably \$1 to \$2 million hospitalization, during which other
24 illnesses were discovered, and they were referred to me.

25 So the point of this is the real problem in this person,

1 in addition to medical problems, was serious alcoholism and
2 other substance abuse. So after \$1.5 million, hospital
3 admission, all kinds of serious stuff, the person shows up on
4 my doorstep. I'm going to get paid \$130 to fix this. And we
5 spent 45 minutes together, and the long and the short of it is
6 I did the best that I could, which was find an AA meeting,
7 extract a promise from her, get a friend to take her. And you
8 know, we're falling on the entities, like AA, in the
9 community.

10 To me, it's absurd that we'll spend \$1.5 million and then
11 dump a person on the street with no hope or help. And she had
12 serious medical problems. She was on -- this makes sense to
13 people in medicine, but she was on 80 units of insulin and
14 didn't know she was a diabetic two weeks prior to that. You
15 know, nobody who is drinking hard and smoking crack is going
16 to be able to manage that.

17 So the result of this, normally, is a bounce back,
18 probably several of them, each costing a huge amount of money
19 and results in a person's early demise. I'm not equipped,
20 particularly not for \$130, to fix that, and it's an
21 unrealistic expectation of us, but that's a kind of typical
22 example, and this is a person who probably didn't cost that
23 much up until then, but is now in that 10% of the population
24 that costs 60%. And if I were an insurer, I would be
25 desperate to not insure her for her next admission.

1 COMMISSIONER ERICKSON: Any final questions or comments
2 related to our behavioral health recommendation before we take
3 a break?

4 CHAIR HURLBURT: Let's -- we're a few minutes early, and
5 we want to start the next session right on time because we're
6 going to have the webinar.

7 COMMISSIONER ERICKSON: It actually won't be webinared.
8 I'm sorry. This -- yeah (affirmative). We're not webinaring.

9 CHAIR HURLBURT: It's on the phone.

10 COMMISSIONER ERICKSON: It's on -- yes. We're
11 teleconferencing in our consultants. I just wanted to make
12 sure folks on the phone realize that they are not going to be
13 able to see the slides.

14 CHAIR HURLBURT: So we'll take a break until -- come back
15 maybe just a few minutes before quarter past. Thank you.

16 9:53:59

17 (Off record)

18 (On record)

19 10:12:40

20 CHAIR HURLBURT: If we can go ahead and get started now,
21 we're going to have the initial report to us on the draft
22 report as it stands now on the analysis that's been done
23 looking at health care pricing in Alaska that Milliman has
24 been doing. I'm going to turn it over to Deb. Our speakers
25 are online with us here. Go ahead, Deb.

1 COMMISSIONER ERICKSON: So I just wanted to note for
2 folks in the room and on the phone, this is -- the first phase
3 of the Milliman study draft report is due from them next week
4 on September 1st. And so this is just a preliminary report
5 from them on the initial draft and so we're not making this
6 available to the public right now. So I apologize for folks
7 on the phone. You won't be able to see the slides. We're not
8 posting those on the Web, like we are the other presentations.

9 But I'm going to go ahead and turn it over now to our two
10 lead consultants at Milliman who have been working on this
11 project for us, Edward Jhu and John Pickering, and they both
12 are on the phone from their office in Seattle, and I will just
13 walk through the slides. If you guys, Ed and John, want to
14 tell me when to transition the slide, I'll be doing that. And
15 I'm not going to spend any time talking about process right
16 now. They're going to over, I think, with us just some of the
17 information on what this phase of the project is about. So
18 I'll leave it to them to do that as part of their
19 presentation. Then we'll see if -- well, we should have
20 plenty of time after their presentation for questions and
21 discussion. So Ed and John, are you on?

22 MR. JHU: We're on. Thanks a lot for that intro, Deb,
23 and we'll get going. Just for those of you who don't
24 recognize the voices, this is Ed Jhu here.

25 MR. PICKERING: And this John.

1 MR. JHU: And with regard to questions, just to clarify,
2 we're certainly open to questions throughout the presentation.
3 So if anybody has any, feel free to chime in. The other
4 piece, since we're doing this by teleconference, we may or may
5 not be able to, obviously, see all the questions. So Deb, if
6 you could -- if somebody does have a question and it doesn't
7 seem like we're stopping, please try to interrupt us and get
8 the question in, and functionally, we'll try to stop
9 periodically, too, and pause, just to make sure that everyone
10 can get them through.

11 COMMISSIONER ERICKSON: Will do.

12 MR. JHU: So starting on the PowerPoint slides, slide one
13 is just a header slide. Slide two has a quick introduction
14 about us at Milliman. I'm not going to spend too much time on
15 this slide, other than just, you know, we are an international
16 consulting firm with a very significant presence, you know,
17 one of the leaders within the health care consulting within
18 the United States, and we've been around for several years at
19 this point. So we would certainly like to think of ourselves
20 as a fairly reputable organization and one that, frequently,
21 is hired by a lot of clients who are looking for our
22 impartiality more than anything else, given that we have no
23 external ties to insurers, brokerage organizations, or anybody
24 else that would potentially lead to conflicts of interest.

25 Moving into slide three, this is a quick map here of the

1 United States and the comparison that we've been asked to
2 perform. And what we've been asked to do is to compare health
3 care costs in the state of Alaska against a set of comparison
4 states, which has been established as Washington, Oregon,
5 Idaho, Wyoming, and North Dakota, and the comparison states
6 were chosen largely for their geographic proximity as well as,
7 to the extent possible, trying to get states that are somewhat
8 similar to Alaska in terms of virility and/or the health care
9 payer environment.

10 Moving next into slide four, this is a quick summary of
11 the analyses that we have performed to date and what we're
12 going to be performing. The first two-thirds of the analysis,
13 you know, really were performed in the same stage and that's
14 what we're just getting close to wrapping up now and what
15 we're going to be discussing today, and it's really discussion
16 of where Alaska reimbursement falls relative to the other
17 comparison states.

18 There is a general expectation that reimbursement in
19 Alaska is higher than the other states, and without drawing
20 the suspense out for too long, that's definitely what we've
21 found in our analysis here, and we'll get into more specifics
22 later on. And that was true across both physicians and across
23 hospitals and other facilities, and you know, has been true
24 across many different combinations of payers, physician
25 specialities, et cetera.

1 So that's what we'll be discussing today with the intent
2 then that, over the next couple months, we'll be following up
3 with additional studies to really try to look at the reasons
4 for why those costs are higher in Alaska, and ultimately,
5 trying to understand whether the higher costs are justified or
6 whether there are, potentially, other reasons, with the goal
7 of, ultimately, trying to figure out if the reimbursement
8 should be where it is today. And we'll touch on some of those
9 analyses later on, as far as some of the preliminary
10 methodologies we're planning on using there, but to this
11 point, we haven't begun, to a great extent, any of the
12 analyses to discuss the reasons for the higher reimbursement.

13 Moving next into slide five, this just gives a broad
14 overview to the methodology that we used on the physician
15 side. And from a process standpoint for today's presentation,
16 we're going to go over the physician in full first, then the
17 facility portion, and then touch on what's going to happen
18 next as far as those drivers, analyses.

19 So we compared both billed charges and allowed charges
20 within Alaska against each of the comparison states, looking
21 both across payers and where, for the payers, we had looked at
22 Medicare, Medicaid, TRICARE, VA, Worker's Compensation, and
23 commercial insurers, so really, a pretty broad and
24 comprehensive set of payers.

25 And then looking at specialties, we had looked at the

1 list of specialties that's included here on the slide. I
2 won't read them all, but again, a fairly comprehensive list of
3 specialties as well as looking at the overall totals across
4 all specialties.

5 What we did to make things a little more concrete is we
6 had, for each specialty, identified the top 25 most frequently
7 used procedure codes and did the same also for the overall
8 across all specialties, then pulled the fee schedule payment
9 for each of the payers for those CPT codes, and then,
10 essentially, aggregated that together to a comparison to try
11 to get to a somewhat easy-to-understand single metric that
12 could be used to evaluate Alaska reimbursement relative to the
13 other states.

14 Moving into slide six, again here is the list of the
15 payers that we had used for the analysis. For the most part,
16 we had used the 2011 fee schedules. For the Medicaid, since
17 each state sets its own fee schedules and since the exact
18 timing for updating those fee schedules, similarly with
19 Worker's Compensation, we had pulled, essentially, the current
20 fee schedules as of today.

21 Then looking at the commercial -- for commercial
22 carriers, there are no explicit fee schedules, or we say that
23 every payer within each state sets its own fee schedules with
24 the various providers, and therefore, there is no single
25 uniform fee schedule. As a result, instead of being able to

1 pull an explicit fee schedule, we started with 2009 data from
2 the Thomson Reuters MarketScan database, which is a fairly
3 broad database that collects data from a number of commercial
4 payers and employers and includes fee information, including
5 the allowed charges for each claim. We had used that to
6 summarize for all of the desired CPT codes the mean, median,
7 and 80th percentile of reimbursement during 2009, which was
8 the data period, and have included that in our analysis here.

9 And finally, we did something similar with bill charges.
10 For those of you not familiar with bill charges, it's,
11 essentially, what the providers themselves -- it's their list
12 price, for want of a better term, but from a practical
13 standpoint in health insurance, almost nobody pays bill
14 charges, and as a result, the commercial allowed charges that
15 were just up above it are really probably the better
16 indicator, as far as how much is actually being reimbursed to
17 payers within each state.

18 Moving next into slide seven, this just shows a quick
19 example of what we ended up doing for the physician
20 reimbursement. And again, we had done this at the individual
21 CPT code levels, but what you'll end up seeing in the final
22 slides that are coming up is an aggregation across all the
23 various CPT codes. Essentially, with six payers, six states,
24 25 CPT codes, and 18 specialties, you can understand the
25 number of numbers that you would be seeing, if you tried to

1 look at all of them, was fairly exhaustive. So we had tried
2 to simplify this down to cemetrics that really make it easier
3 to understand the relative reimbursement. But essentially,
4 all we had done here was take the Medicare -- take the
5 relative fees for a given payer and a given specialty across
6 the six states. We calculated the average across the five
7 states, excluding Alaska, and then determined the relative
8 percentage of the average fee for each state relative to that
9 average across the five non-Alaska states.

10 As an example, the \$110 fee in Alaska divided by the \$92
11 average for the five comparison states gives us 120%
12 relativity just in that Alaska is paying 20% more than the
13 average across the other five states.

14 COMMISSIONER ERICKSON: Ed, just a couple of things. We
15 have a question from one of our commissioners here in the
16 room, but I just wanted to make sure folks understand, too,
17 while for the purpose of this presentation and then probably
18 the body of the report, the consultants are doing some --
19 presenting summaries and aggregated data, but we will have the
20 more detailed data reports as an appendix to the report; is
21 that correct, Ed?

22 MR. JHU: Yes. What we're planning on doing, really, is
23 just issuing two different versions of the report, one of
24 which doesn't have the appendix, since the appendix will be a
25 fairly lengthy appendix, and then the second version will also

1 have the appendix attached for those that are interested in
2 the deeper details.

3 COMMISSIONER ERICKSON: Very good. David?

4 COMMISSIONER MORGAN: Yeah (affirmative). This is Dave
5 Morgan. Deb thought I was probably going to ask a very
6 specific question on the DRG. I wasn't. What I was going to
7 ask you is, did you also do a questionnaire or a review of
8 availability of access for Medicare and Medicaid in some
9 measurement form, like did the -- like for Medicare, did
10 Medicare patients have easy access, no problem getting a
11 primary care physician? Is there anything in there about
12 ability to get a physician based by each of those state's
13 relationship and what is reimbursed?

14 MR. JHU: Not at this point. The analysis that we've
15 done, to this point, is truly based purely looking at the
16 actual reimbursements without really considering the whys or
17 how effective that reimbursement is. That's really where
18 we'll be getting into the second part of the analyses in the
19 next couples months is, you know, looking at the reasons for
20 the reimbursement. And so some of things we have been
21 contemplating are, it seems like, physician staffing ratios or
22 other sources that would help to get at some of the drivers
23 behind that reimbursement, and I would think some of that
24 would fall under various types of access. At this point, you
25 know, we're not planning on having any explicit questionnaire

1 or survey type of approach, but we are just going to look at
2 the various metrics that are out there and try to get a deeper
3 explanation of why the reimbursement has gotten to where it
4 is.

5 COMMISSIONER ERICKSON: Another question? Not yet. I
6 think we're ready for you to go on then, Ed.

7 MR. JHU: Great. So then moving into slide eight is the
8 first slide where we're showing the true results for the
9 physician reimbursement, and the way to interpret this slide
10 is to look at each row for each line on the table and compare
11 the numbers to the other lines on the table. So for example,
12 this first line here for Medicare is showing the relative
13 reimbursement in Alaska compared to the average of the five
14 comparison states. And so the 124% here would show that
15 Medicare reimbursement in Alaska is 124% of the average
16 reimbursement of the other five states.

17 Similarly, the line below, TRICARE, shows that TRICARE
18 reimbursement in Alaska is 177% of the reimbursement in the
19 other five states, but on this slide here, you shouldn't
20 compare the 124 and the 177 because those numbers aren't
21 directly comparable since the Medicare number is compared to
22 the Medicare reimbursement in the other states and the TRICARE
23 number is compared to TRICARE reimbursement in the other
24 states. We do have some slides later on that show equivalent
25 numbers where we're comparing across the payers within each

1 state.

2 So looking down the numbers, it's fairly clear that
3 Alaska reimbursement is higher than each of the other states
4 and significantly higher than the average of the other five
5 states. The number at the bottom in the all payers shows 155%
6 and so that's the average reimbursement in Alaska relative to
7 the other states applying a (indiscernible - voice lowered)
8 across payers, which is shown at the bottom of the slide here
9 and that reflects approximate nationwide averages in terms of
10 the relative proportion of health care payments from the
11 various sources.

12 A couple things to note in here, as shown in the
13 footnotes, TRICARE and Medicare, in some cases, have multiple
14 fee schedules within states. Within Washington here, they
15 have a separate fee schedule for the Seattle area versus the
16 rest of the state, and similarly in Oregon, a separate fee
17 schedule for Portland versus the rest of the state. For
18 purposes of this analysis or these slides here, we've shown
19 Washington as being represented by just Seattle and Oregon as
20 represented by just Portland, but again with the detailed
21 exhibits that will be showing up in the appendix of the final
22 report, we will include both the rest of Washington
23 reimbursements and the rest of Oregon reimbursements, in
24 addition to the Seattle and Portland area reimbursements.

25 A couple other disclaimers or notes. What we've shown

1 for VA here is the reimbursement that VA pays for any care
2 that they're reimbursing external providers for on a non-
3 contracted basis. In the case of VA, the vast majority of
4 their health care claims are provided, essentially, in-house
5 as a staff model type of environment where VA hires, you know,
6 physicians and builds facilities, and essentially, then
7 doesn't have any explicit internal reimbursement process for
8 that, but there are cases in which VA will pay for care from
9 the private sector. And so what we've shown here is the VA
10 reimbursement on that basis.

11 COMMISSIONER ERICKSON: Ed, we have a question.

12 MR. JHU: Yes?

13 COMMISSIONER CAMPBELL: Keith Campbell. What would
14 including the whole state numbers for Oregon and Washington do
15 to these percentages?

16 MR JHU: Not an awful lot. It's not that different
17 between Oregon and Washington versus the rest of the state and
18 between Seattle and Portland versus the rest of those states.
19 And the Seattle and Portland numbers are, in fact, are higher
20 than the rest of the state, typically. So that the numbers
21 might move, such that Alaska may be very minimally higher than
22 the 155 we're seeing now, if we included those other two, but
23 it certainly wouldn't have a material impact on things. There
24 would be change to our conclusion.

25 COMMISSIONER CAMPBELL: Then why wouldn't you use them,

1 the whole state numbers?

2 MR. JHU: Well, what it is, is that there is actually two
3 separate fee schedules in Oregon, one for the Portland and one
4 for the rest of the state, except for Portland. So we could
5 have chosen to use the rest of the state, except for Portland.
6 We figured that's the majority of the population for the
7 health care costs are probably within Portland. The other
8 option would have been to either take a blended average of the
9 two or to, you know, double weight Oregon and Washington by
10 including both fee schedules in our average. For our
11 purposes, we have chosen to use Portland and Seattle, again,
12 largely because it didn't materially affect the conclusion.
13 But if there are concerns about that, we can certainly present
14 our final report differently, if there are preferences
15 otherwise.

16 COMMISSIONER CAMPBELL: I prefer it in the final report
17 as an appendices or something like that because that question
18 will come up from somebody in the population. Thanks.

19 MR. JHU: And again, certainly, the appendix, itself,
20 will contain the detailed fee schedules for both Portland and
21 the rest of Oregon and the same for Seattle and the rest of
22 Washington. It's just a matter of what to choose for creating
23 these summaries up front, and the report will definitely be
24 clear about that as to the fact that we have used Seattle and
25 Portland as representative of the case for Medicare and

1 TRICARE.

2 COMMISSIONER ERICKSON: We're ready for you to go on.

3 MR. JHU: So a couple of other disclaimers here also with
4 regard to the state of Wyoming. Both the Worker's
5 Compensation fee schedule in Wyoming isn't readily externally
6 available. It relies on a set of relative values that are
7 developed by Ingenix as part of a proprietary product they
8 have. So we weren't able to include Wyoming's Worker's
9 Compensation within this particular analysis. And similarly,
10 we've only limited -- been able to include Wyoming's Medicaid
11 reimbursement on a somewhat limited basis. The state of
12 Wyoming doesn't actually release their fee schedule for
13 Medicaid in a very readily available format, and instead,
14 requires individual look-ups of individual CPG codes as we
15 proceed through.

16 So we've included the CPG codes for the top 25 overall as
17 part of our analysis. To this point, we haven't included
18 necessarily any CPG codes that might have shown up in the top
19 25 for a particular specialty, but not across all specialties.

20 COMMISSIONER ERICKSON: Ed, we have another question.

21 MR. JHU: Given the analyses we've seen so far and given
22 the disparity between Alaska and the average of the other five
23 states, again, I would be comfortable stating that, including
24 Wyoming's Worker's Compensation, or more broadly, including
25 Medicaid, it wouldn't change the conclusions that we're

1 reaching.

2 COMMISSIONER ERICKSON: Ed, we have another question.

3 COMMISSIONER LAUFER: Hi, this is Noah Laufer from
4 Primary Care Doc in Anchorage. One of our big problems is
5 access to Medicare for Medicare B, primary care. Do you
6 differentiate in these costs between Medicare A and Medicare B
7 as a payer?

8 MR. JHU: What this is, this is a physician reimbursement
9 under Medicare. So it would be, essentially, all under
10 Medicare, Part B. What we've got -- in the following slides,
11 we'll talk about the facility component, which will include
12 both the hospital inpatient portion under A and the hospital
13 outpatient portion under B.

14 COMMISSIONER LAUFER: Another question, sort of more to
15 the meat of the matter is there is a big difference between
16 reimbursement and compensation. I own my own business, and my
17 reimbursement also pays for -- you know, covers my
18 compensation, but it also covers the cost of my providing
19 health care to all of our employers which is, obviously,
20 higher. I think the devil is in the details here, and what
21 I'm worried about is what questions are we asking and why, and
22 are they really going to provide us with anything, like a
23 solution?

24 MR. JHU: To address that, certainly, you are right. We
25 are referring here just to reimbursement as far as allowed

1 charges, and essentially, the total amount that physicians are
2 receiving from the payment and that's the first half of this
3 report, but one of the things that will be included in the
4 second half of the report that will be released in a couple
5 months is, as part of the driver, a review of salaries and
6 compensation for health care staff in Alaska versus -- in that
7 case, we'll just have the Northwest states, Washington,
8 Oregon, and Idaho, but some of that will get to the root of
9 things as far as the drivers of why the health care costs are
10 higher, and hopefully, be able to establish whether or not
11 those drivers are sufficient to explain the reimbursement that
12 we're seeing.

13 COMMISSIONER LAUFER: I'm sorry. I have a lot of
14 questions, but another question in regard to access to primary
15 care is, is this is just physicians? Does it include nurse
16 practitioners, PAs, naturopaths and other people who are
17 billing the similar codes?

18 And then an obvious other difference is we don't really
19 have a system. We have an aggregate of a lot of different
20 things. Many primary care docs are either employed by the
21 Native system, by the military, by hospitals, by residencies,
22 by Neighborhood Health. It's a minority, I would think, of
23 primary care docs who are actually in private practice, and
24 again, the reimbursement goes to a large entity in that case,
25 and the compensation is a salary, which is substantially less.

1 MR. JHU: So what we will be referring to here is not the
2 compensation from the private entity to the physician. It's,
3 essentially, the compensation that's provided to, you know,
4 the physician or whatever organization is employing the
5 physician by Medicare or Medicaid or the various organizations
6 in exchange for that service. So certainly, this does not
7 necessarily reflect how much of that reimbursement will,
8 ultimately, be passing through to, you know, this addition as
9 take-home pay or as money in his or her pocket.

10 COMMISSIONER LAUFER: Thanks.

11 MR. JHU: Any other questions?

12 COMMISSIONER ERICKSON: No. You can go ahead.

13 MR. JHU: So carrying on then, we had, again, looked at
14 this particular exhibit, which is comparing reimbursement by
15 payer across states.

16 The next exhibit transforms so that, instead of looking
17 at the reimbursement across states within a specific payer,
18 this is now looking at the reimbursement across payers within
19 a specific state. So essentially, we wanted to look at the
20 columns here in slide nine instead of the rows. And so now a
21 slightly different interpretation. The 71% under Medicare in
22 Alaska shows that Alaska Medicare is paying 71% of the average
23 across all payers in Alaska, and by comparison, you can see,
24 relatively speaking, you've got Worker's Compensation with the
25 highest reimbursement followed by the commercial payers, VA,

1 then TRICARE, and Medicare and Medicare.

2 Looking across at the other states, you see somewhat
3 similar patterns. Probably the biggest thing that stands out
4 here and is consistent with what we've seen elsewhere is the
5 higher reimbursement of Medicaid compared to Medicare in
6 Alaska. Certainly, it's not unique, but in general,
7 typically, Medicaid reimbursement tends to be lower than
8 Medicare, you know, on average nationwide.

9 I'll give you a second to absorb the numbers here in this
10 slide.

11 COMMISSIONER ERICKSON: And we do one question.

12 MR. JHU: And if you have any questions -- yeah
13 (affirmative).

14 COMMISSIONER ERICKSON: Yeah (affirmative). We do have a
15 question, Ed.

16 COMMISSIONER MORGAN: This is Dave Morgan again. This is
17 not so much a question, but more of a -- just to put a thought
18 out there. Even though tribal health and community health
19 centers utilize the same coding system for reimbursement for
20 Medicaid, we do get reimbursed in a different way that's not
21 based necessarily on that code. We -- FQHCs get a Medicaid
22 reimbursement. We have a higher percentage, if you take the
23 patients of community health center patients as a percentage
24 of population. We have one of the highest percentages of
25 tribal patients as compared to these other states, not in

1 numbers but in percentage. So you have tribes, tribal
2 entities that are reimbursed for Medicaid on an encounter
3 rate, inpatient and out, and you have FQHCs under community
4 health centers that are, basically, reimbursed on a cost-based
5 system, too, on an outpatient basis.

6 So just a thought is we may have to do -- you may have to
7 do some tricky calculations here to mitigate that into the
8 percentages from a statistical standpoint, or at least, show
9 that it's not affecting it. It seems, to me, in that addendum
10 maybe you have. You don't have to answer the question. I'm
11 kind of just mentioning that as we go through. It's hard to
12 compare Alaska to Washington when you take the percentage of
13 tribal patients as a percentage of population, especially in
14 Medicaid and Medicare and FQHCs because, unlike our colleagues
15 at the table who are private physicians that bill and get paid
16 for that code, we have an encounter. And sometimes, there
17 will be nine codes in there because it's getting paid for the
18 nine activities in the encounter. So I mean, hey, why not
19 make it as complicated as we can is what I always say? But I
20 just think we need to, at least, address that in the addendum
21 saying hey, we looked at this and it has a 0.2% effect, plus
22 or minus or something. That's from Mike Foster, our economist
23 consultant, to kind of put that in as a note or something.

24 MR. JHU: And to be honest, to this point, we haven't
25 looked at any special reimbursements as far as tribal or

1 native nations. We'll certainly consider that, especially as
2 we get into that -- in the second part of this report as far
3 as identifying the drivers of the reimbursement differentials
4 and whether that's a material portion that may explain some of
5 what we're seeing. So thanks for that comment. Any other
6 comments or questions in the group?

7 COMMISSIONER ERICKSON: Not at this point, Ed.

8 MR. JHU: Thanks. Moving into slide ten, this is similar
9 to slide eight in that we're, once again, back to comparing
10 Alaska to the average of the other five states. The
11 difference here is that, instead of looking at the results by
12 payer, we're now looking at the results by specialty, and we
13 have aggregated results across payers using the same
14 percentages that we had used in slide eight to get to that all
15 payer total. And so you know, once again, a fairly similar
16 set of conclusions as far as the reimbursement in Alaska,
17 relative to the average of the other states.

18 One number that jumps out that I did want to make sure is
19 interpreted with a grain of salt is the interventional
20 cardiology. It's a fairly high number here. Unfortunately
21 what's happened with interventional cardiology is that the
22 most frequently used CPG codes have actually been changing
23 over the past couple years. Between 2009 and 2011, basically,
24 the codes were recast to, presumably, develop a little more
25 accurate set of CPG codes. But as a result, it has been a bit

1 of a challenge to do the comparison across various fee
2 schedules, some of which may be listed under the old codes and
3 some under the new codes, et cetera. So that number, in
4 particular, is standing out. I wouldn't put too much weight
5 on it, but certainly, looking at the other specialties, you
6 can see the relative reimbursement there and that, for the
7 most part, the rest of them are fairly similar in terms of how
8 Alaska compares to the other states.

9 COMMISSIONER DAVIDSON: I'm just going to jump in here.
10 I have a question. For some of these slides where you're
11 doing -- where you show the amount and there is either a
12 highest to lowest or whatever -- there's a range there, in
13 your next iteration of this slide and other slides similar,
14 can you just resort the list from highest to lowest or lowest
15 to highest in some way, so that we don't have to manually go
16 through and number them?

17 MR. JHU: Yeah (affirmative). We can do that.

18 COMMISSIONER DAVIDSON: And since this study is for
19 Alaska, then, obviously, the Alaska piece is the one we're
20 most interested in. So if you could do that, that would
21 really help. Thanks.

22 COMMISSIONER DAVIS: Ed, this is Jeff Davis. I have a
23 question about this slide ten. Because -- well, it's a
24 hypothesis that I want to test with you. I'm thinking that,
25 because this is all payer, it is going to mask some of the

1 differences. So based on the slide prior to that -- for
2 example, if Medicare is 71% of the market average and
3 commercial allows 121%, with those two numbers in mind, if you
4 mush it back together into an all payer, it's going to mask
5 the difference between what Medicare reimburses and what a
6 commercial payer reimburses; is that correct?

7 MR. JHU: Yeah (affirmative). Essentially, we've blended
8 them together. The one thing that we did do is, when we
9 blended across payers, we used the same percentages across
10 each payer. I'm sorry. I mean, the same percentages for each
11 payer within each state and that's in the footnote there in
12 number two below. And the intent of that was to make sure
13 that a difference in the relative payments or the relative
14 size or volume of the payers within each state didn't obscure
15 in the fee schedules themselves.

16 COMMISSIONER DAVIS: Let me try again. So I'm thinking,
17 if we looked at it family practice and we looked at it for
18 Medicare, we would see a number much lower than the 148% we're
19 seeing for Alaska here, but if we looked at then commercial
20 allowed by itself, we would see a number that's significantly
21 higher than the 148; am I interpreting this correctly?

22 MR. JHU: I don't think so, and it may be, but that's not
23 necessarily true, that what we're comparing here is a blend of
24 all the Alaska payers against a blend of all the payers in the
25 other states and that 148. Certainly, the commercial payment

1 would still be higher than Medicare for family practice. At
2 the same time, that's presumably true in each of the other
3 five states also.

4 MR. PICKERING: Let me jump in here, too, because I think
5 Jeff is right, and Deb, if you could flip back to slide eight
6 real quick, what that shows -- you know, it's not by specialty
7 but it is, essentially, similar to slide ten in that except
8 that it's by payer without having the specialty element, and
9 you can see there Alaska Medicare relative to Medicare in
10 other states is only 24% higher, but if you look at, say, the
11 commercial allowed mean, it's 59% higher than the other
12 states' average. So if you look back to slide ten then, well,
13 we can't look at that family practice value in Alaska, 148%,
14 and say conclusively that commercial would be, you know,
15 higher than 148 and Medicare would be less than 148. That's
16 probably the case. You know, in our report, itself, we'll be
17 able to show a lot more detail and show exactly what the
18 numbers are, but I do think, Jeff, that you're right, that, in
19 all likelihood, the commercial number would be higher than
20 these averages shown on slide ten and the Medicare number
21 would be lower.

22 MR. JHU: But just to clarify, that would be the case
23 only because the commercial in Alaska relative to the states
24 in Alaska is higher than Medicare in Alaska relative to
25 Medicare in other states, rather than just purely because

1 commercial reimbursement in Alaska exceeds Medicare
2 reimbursement in Alaska.

3 COMMISSIONER DAVIS: Great. Thanks. That was helpful.

4 MR. JHU: Any other questions on the specialty slide?

5 MR. PICKERING: You know, one other thing I would point
6 out on this slide that, I think, is a takeaway, when you look
7 at DME, the Alaska percentage relative to the other states is
8 117%, which is quite a bit lower than any of the other
9 specialties. Of course, the other specialties are all
10 professional time as opposed to, you know, equipment, and it
11 may be that, for whatever reason, payers have been able to
12 stick with lower, or you know, rates in Alaska closer to the
13 rest of the country on the equipment, but not professional
14 time.

15 COMMISSIONER ERICKSON: We have a question.

16 COMMISSIONER LAUFER: This is Noah Laufer again. Again,
17 I'm a primary care doc, and when I looked at this, it's
18 similar to compensation disparities between primary care and
19 specialties, but the conclusion is a doctor, as a businessman,
20 that I would draw is the closer I am to technology or to the
21 big hospital, i.e. the more meetings I go to at the hospital,
22 the more I make. And you know, that's a Machiavellian
23 observation, but it's definitely true. There are a couple
24 outliers that, I think, can easily be explained, like
25 gastroenterology or neurology. Neurology is demand. We don't

1 have enough, and gastroenterology is the advent of the
2 colonoscopy, which is necessary and needed and not quite
3 expensive enough to go out of state for. Thanks.

4 MR. JHU: Moving forward then into slide 11 and this,
5 essentially, summarizes the conclusions that we've discussed
6 already. So I think I'll just flip past that into slide 12.

7 And over the next few slides, what we're going to be
8 discussing is, as I mentioned earlier, the, you know,
9 percentages that we're looking at were, based on a point in
10 time, based on the current fee schedules and places where
11 there are fee schedules and based on allowed charges and
12 billed charge information from a 2009 database.

13 What we found though, and there are some sources here to
14 support that, is that the relative reimbursement across states
15 has changed significantly over time, both within Medicare due
16 to differences and changes in how Medicare is applying
17 geographic adjustments over time, and within Medicaid, since
18 the Medicaid schedules, themselves, are controlled by each
19 state, and therefore, as different states have had different
20 views of Medicaid reimbursement, there have been substantial
21 changes in the relative reimbursement across states.

22 Starting first with Medicare, Medicare for physician
23 reimbursement uses their Geographic Practice Cost Index
24 factors, referred to as the GPCIs. And essentially, Medicare
25 breaks physician reimbursement up into three components, and

1 for each geographic area, applies a different adjustment
2 factor to each of the three components of the service
3 aggregated set back together and that's how Medicare develops
4 their total reimbursement for a specific service in a specific
5 area.

6 Within -- larger metropolitan areas will have their own
7 set of GPCI factors. Within some of the less populated states
8 and for the rural and smaller areas in more populated states,
9 there was a single factor that would apply to a given state.

10 So within the comparison states that we are working with
11 here, Alaska, Idaho, Wyoming, and North Dakota each have a set
12 of factors that apply statewide. It varies among those four
13 states, but within each of those states, there is a single set
14 of factors, and as we touched on earlier, within Washington
15 and Oregon, there are two sets of factors each. Within
16 Washington, there is one for Seattle and one for the rest of
17 the state, and one for Oregon, one for Portland, and one for
18 the rest of the state.

19 CMS has some rules in place as to how to develop those
20 GPCI factors, and they update them each year. That being
21 said, there have been a number of legislative actions that
22 have taken place recently that have overridden the GPCI
23 factors in a number of cases. I summarized some of the key
24 ones here at the bottom that the work component of the GPCI,
25 there has been a provision in place the past couple years

1 that's being renewed on a somewhat annual basis to put a 1.0
2 floor on the work component of the GPCI. And just to give
3 perspective, essentially, the average of the GPCI factors when
4 they're in their pure form is approximately 1.0. So a 1.0
5 floor, essentially, says that everybody who is below average
6 is being pushed up to the average prior to the floor.
7 Obviously, it's not reinflated in that the 1.0, once you've
8 applied this sort of floor, is still less than the overall
9 average across everybody because the overall average has
10 increased because of pushing everybody who is below it up to
11 what the prior floor is, but in general, it's increased
12 reimbursement for some of the lower cost areas.

13 Similarly, there was a provision that was put in place as
14 part of the Health Care Reform Act last year on the practice
15 portion of the GPCI that put in a 1.0 floor for what we'll
16 refer to as frontier states, which, for the comparison state
17 group, includes both North Dakota and Wyoming and also puts
18 some provisions in place that increase the practice component
19 of the GPCI for other states where the practice GPCI was below
20 one previously. And then within Alaska, the most significant
21 provision was, beginning in 2009, a provision that set the
22 Alaska work GPCI at 1.5 as compared to the GPCI that was in
23 effect immediately before that, which is 1.017, essentially
24 right around one.

25 And this next table here shows those numbers and shows

1 the change caused by that work GPCI floor and by the practice
2 expense changes from 2010 to 2011. Since this is '10 to '11,
3 it doesn't show the impact to Alaska, but we've got that here
4 as a footnote. And just to give some perspective, roughly
5 speaking, the majority of physician reimbursement is in that
6 work component, the practice expensive component, and very
7 broadly, they are approximately equal. So you can see the
8 impact of these various changes on the various geographic
9 areas by looking at approximately the average between the work
10 GPCI components and their change from 2010 to 2011.

11 So looking, for example, at North Dakota, you see that
12 you've got a 6% work GPCI and an 18% practice expense GPCI
13 increase, due to these legislative provisions, which, roughly
14 speaking, is increasing Medicare reimbursement for physicians
15 in North Dakota by about 12%. By comparison, these changes
16 are actually doing nothing in Portland, such that Portland
17 reimbursement is unaffected by those.

18 Within Alaska with this 1.5 GPCI already established,
19 there is no change from '10 to '11. That being said, the
20 increase from the 1.017 GPCI in 2008 to the 1.5 GPCI in 2009
21 would have increased physician reimbursement in Alaska for
22 Medicare by approximately 25%.

23 All this, you know, mostly to say that there have been
24 significant changes, not all of which are driven by the pure
25 numbers from CMS, and in many cases, driven by legislative

1 factors. There are certainly -- you know, this is all in the
2 past few years that many of these changes have taken place.
3 It is certainly the likelihood that things will continue to
4 change over time as additional taxes are built in.

5 As an aside, one of the things being considered at this
6 point is a change in how Medicare develops their geographic
7 adjustment payments for physicians. If it goes through with
8 the latest recommendations from the Institute of Medicine,
9 essentially, it would create a much more refined set of
10 geographic adjustments, closer to, or basically, using the
11 same geographic definitions as what's being used on the
12 facilities side of things where, instead of roughly 100
13 different areas nationwide, we'd be looking at about 500 or so
14 in different areas.

15 And so with that again, we'll throw the process
16 potentially into flux and a bit of turmoil, and it will likely
17 result in some changes as far as the relative payments for
18 Medicare across the states. Any questions or comments with
19 regard to (indiscernible - voice lowered)?

20 COMMISSIONER ERICKSON: There are none here.

21 MR. JHU: In which case, moving on. Slide 14 shows some
22 similar information from Medicaid. And so this is looking at
23 Medicaid reimbursement as posted by www.statehealthfacts.org,
24 which is a website produced by the Kaiser Family Foundation.
25 And what's being shown here is the most recent data that they

1 had available, which is changes in Medicaid fees from 2003
2 through 2008. Well, you can see here the vast disparity
3 across states in terms of Medicaid reimbursement where, over
4 that five-year period, there were states, like Minnesota and
5 New York, that had no change at all in their Medicaid
6 reimbursement on average, and by comparison, states, like
7 Oklahoma and Pennsylvania, that are at or above a 60%
8 increase. And even within the group of states that we're
9 looking at, we've got a range from a very minimal increase in
10 Alaska at 3% to almost 50% in Wyoming.

11 It's certain that there have been similar changes from
12 2008 through today, and with many states in budget crises,
13 they're looking to level their budgets as much as possible.
14 It's certainly possible that there is going to be some fairly
15 significant changes going on in the next few years as far as
16 Medicaid reimbursement which will, likely again, change the
17 picture of the relative reimbursement that we're showing for
18 Medicaid now by state compared to what it might be in five
19 years.

20 CHAIR HURLBURT: Ed, this is Ward Hurlburt. I have a
21 question related to Washington State. My guess is, and I may
22 be wrong -- tell me if I'm wrong on that -- looking at the
23 18%, that would represent not an across-the-board 18%
24 increase, but it reflects the kinds of things that Christine
25 Gregoire did when she came in, where the E&M codes, for

1 example, for pediatric patients were pretty dramatically
2 increased, and other increases were much less. If that's
3 true, would that be true for most of the other states, that
4 they weren't across-the-board increases, but what might be
5 specifically targeted to certain areas?

6 MR. JHU: Yes. I can answer that from the point of view
7 of the calculation itself, and again, this is something that
8 we obtained from an external calculation as opposed to doing
9 it ourselves, but it is, essentially, an average increase, you
10 know, across all various types of specialties and various CPG
11 codes, et cetera. And certainly, many of the states are
12 changing their fee schedules over time, not just, you know,
13 applying an across-the-board increase, but tweaking with the
14 relativity as much as Medicare, themselves, do. So I would
15 expect that, in many cases, what we're seeing here, you know,
16 might not be that single across-the-board increase that was
17 uniform, but rather, the aggregated average of, you know, many
18 increases and potentially even some decreases in certain
19 cases. Any other questions or thoughts with regard to this
20 particular slide?

21 And just before we move on, this is actually the last
22 slide that we had on the physician portion of things. So just
23 take a second and leave it back open again, as far as if there
24 are any comments or questions in general with regard to our
25 physician analysis thus far.

1 COMMISSIONER ERICKSON: There aren't any.

2 MR. JHU: Then I'll move forward onto slide 15, which is
3 the start of our analysis on the hospital component of things.

4 On the hospital side of things, we did things slightly
5 differently, in that, obviously, there aren't the vast number
6 of different specialties as far as hospitals, but there is
7 also a very broad range as far as the CPT codes. So rather
8 than looking at specific fee schedule amounts across payers
9 and trying to pick out the top 25 or anything, we had,
10 essentially, applied a method where we took hospital
11 reimbursements in each of the various states, used the
12 detailed claims data to assign relative value units to those -
13 - to the workload, and then compared the reimbursement to the
14 amount of workload that was performed, essentially, to get a
15 factor that represents the average for an equivalent piece of
16 work for each of the states. And this was done on both a
17 Medicare and a commercial basis.

18 The tool that we used to do that is HECS, which stands
19 for the Hospital Evaluation and Comparison System, and RBRVS
20 for hospitals, which is, essentially, a schedule of relative
21 value units that we developed and is a proprietary product of
22 us here at Milliman that tries to mimic the same concept on
23 the physician side that Medicare develops every year for their
24 physician reimbursement.

25 I won't go through the details here as far as the users,

1 but the product is in fairly extensive use, both by us and a
2 number of clients who license the product from us, as well as
3 being used for a number of ad hoc projects similar to what
4 we're doing for you guys here.

5 Slide 16 is just a little bit more background, and again,
6 I won't go through that now, but we will release the final
7 PowerPoint presentation with the final report. And so anybody
8 who is interested can get some more details here, and we do
9 have additional background information, which will be appended
10 to the report, that just describes our (indiscernible - voice
11 lowered) in a little more detail.

12 As I mentioned before, we assigned relative value units
13 to all of the workload, and essentially, developed what we
14 call a conversion factor, similar to Medicare's conversion
15 factors that they use for payment on the physician side. In
16 this case, the conversion factor is calculated as a result of
17 the reimbursement rather than in order to develop the
18 reimbursement methodology, but it will take the total costs or
19 the total allowed charges rather and divide through by the
20 number relative of value units to get to a conversion factor
21 for each facility or each state or any combination thereof.

22 So moving into slide 18 as a quick example, and RBRVS for
23 hospitals is intended to be used with both inpatient and
24 outpatient hospital reimbursement at the same time, but we do
25 have the results broken out in our detailed report separately

1 for inpatient and outpatient services, as well as even more
2 defined categories, such as surgeries or inpatient medical
3 admissions, lab services, radiology, et cetera.

4 But essentially, we have an example here of a set of
5 claims, the top of which is an inpatient admission that lasted
6 three days, and we have the DRG basis there by which the
7 admission was grouped to and then a series of CPG and
8 (indiscernible - voice lowered) codes representing some
9 outpatient services.

10 We combine the total allowed charges, divide the total
11 (indiscernible - voice lowered) across all of these services,
12 and the result gets us a conversion factor, in this case,
13 \$54.46. Again by doing this across sets of claims either
14 looking at individual providers within a state, looking at
15 individual services within a provider, or in the case of what
16 we've done for you here, looking at all the claims across each
17 state compared to each other, you can compare the conversion
18 factors, and essentially, the higher the conversion factor the
19 higher the reimbursement for hospital services and on a linear
20 basis, such that, if a conversion factor for one state is
21 twice as high as a conversion factor for another, it suggests
22 that the first state, on average, is getting reimbursed twice
23 as much for the same service or type of workload.

24 Before I get into the results there, any questions about
25 the methodology?

1 Then moving in to the next slide, slide 19 just shows, on
2 the commercial side, we're again using the MarketScan
3 database, and on the Medicare side, we're using, for inpatient
4 services, the MedPAR file, which includes all inpatient
5 admissions under Medicare during 2009, and on the outpatient
6 side, we're using the outpatient prospect payment system
7 database, which covers any facilities that are paid under
8 Medicare's OPPS and that's the mechanism by which Medicare
9 reimburses the vast majority of outpatient services.

10 Under Alaska, there is a higher percentage of services
11 that aren't going to be included in OPPS because they're
12 critical access facilities are sole community hospitals that
13 are in some of the rural areas, but it still does give a
14 fairly good indication of where the facility reimbursement is
15 in Alaska relative to the other states.

16 So the next sets of slides, we'll be showing the actual
17 results of our facility analysis, and in general, the
18 conclusions are that, once again, reimbursement in Alaska is
19 higher than in the other states. So relatively, the
20 differential isn't as large as it was on the physician side of
21 things.

22 So what we've shown here is the three -- let me take a
23 step back. We mentioned earlier that, within -- for Medicare
24 on the physician side of things, there is a single set of
25 payment rates across the entire state. In general on the

1 facilities side of things, Medicare has a more refined set of
2 geographic adjustments than you do in facilities and that's in
3 all states, not just in Alaska. And as a result, within
4 Alaska, Medicare actually has three separate sets of areas for
5 reimbursing facilities, one for the Anchorage area, one for
6 the Fairbanks area, and one for the rest of the state.

7 To reflect that, we've developed this analysis here
8 showing the relative conversion factors for each of the three
9 areas in Alaska, as well as the statewide total in Alaska
10 compared to each of the various states. And we see here,
11 again, that we've got a conversion factor of about \$120 in
12 Alaska. By comparison, it's about \$80 in Idaho, and
13 therefore, that suggests that commercial reimbursement for
14 facility use in Alaska is about 50% higher than in Idaho.

15 Similar to what we said earlier on the physician side,
16 for commercial, you know, this does reflect a broad range of
17 payers and fee schedules, some of which may have reimbursement
18 structures that vary considerably across the various parts of
19 each state, some of which might be more uniform. And
20 certainly within some of the larger states, such as here in
21 Washington, there is considerable room for disparity as far as
22 even just the overall level of reimbursement between some of
23 the various payers within the state, but what we've got here
24 is an approximate average of the reimbursement for commercial
25 payers in each of the states. Any questions or thoughts on

1 this?

2 COMMISSIONER ERICKSON: Yes. We do have a question.

3 COMMISSIONER DAVIDSON: So for the hospital-commercial,
4 it looks like you added, is that Hawaii?

5 MR. JHU: Yes.

6 COMMISSIONER DAVIDSON: And you didn't do that for the
7 outpatient?

8 MR. JHU: For the -- we did for the facility outpatient.

9 COMMISSIONER DAVIDSON: I'm sorry.

10 MR. JHU: We didn't do that on the physician side of
11 things.

12 COMMISSIONER DAVIDSON: And then.....

13 MR. JHU: In part, it was some discussion from the
14 initial kick-off that John was in attendance and presented our
15 original methodology back in June or July that I think there
16 was a request by the hospital board, in particular, to try and
17 include Hawaii in the analysis. The nature of our methodology
18 was such that adding in additional states on the hospital side
19 was a relative (indiscernible - voice lowered) thing to do,
20 given that we're relying on databases of data rather than on
21 the physician side, where it would have meant that we would
22 have had to find the individual fee schedules in Alaska --
23 sorry, within Hawaii. So we didn't include Hawaii on the
24 physician side of things. Relatively speaking.....

25 CHAIR HURLBURT: Ed, this is....

1 MR. JHU:you know, although Alaska and Hawaii are
2 somewhat bonded together in their -- in separation both
3 geographically, and you know, often times, culturally from the
4 Lower 48, our thought was that there isn't, inherently, that
5 much similarity between the Alaska and the Hawaii health care
6 markets in particular. One major differential being that
7 Hawaii has a very high penetration of managed care within the
8 state, whereas that isn't necessarily true here in Alaska.

9 CHAIR HURLBURT: Ed, this is Ward Hurlburt. I'm going to
10 have you just expand a little bit on that. With Pat and
11 Karen's invitation, I sat in with an ASHNHA meeting, and it
12 was specifically that meeting that a request came to look at
13 Hawaii and that explained that could be done on the hospital
14 side, which is where the request came from, without a lot of
15 extra cost. So that was why that was added on. It was in
16 response to a specific request.

17 COMMISSIONER DAVIDSON: And then the other question I had
18 was, looking at your three categories, Anchorage, several
19 facilities, Fairbanks, one facility, and then everything but
20 Anchorage/Fairbanks includes rural, plus Juneau, right?

21 MR. JHU: Yeah (affirmative). And again, that's based on
22 the geographic adjustment payment definitions that Medicare
23 uses.

24 COMMISSIONER DAVIDSON: Thanks.

25 MR. JHU: Moving then on to slide 21, a similar slide,

1 only this is showing Medicare reimbursement as opposed to
2 commercial reimbursement, and once again, that's a similar
3 sort of set of results. One thing to note is that the scale
4 of the numbers has changed considerably from slide 20 to slide
5 21. In general, not just in Alaska but nationwide, commercial
6 reimbursement of facilities is considerably higher than
7 Medicare, and so as a result, you know, where the scale on the
8 previous slide extended from zero to 140, this one has half
9 the scale where it's extending from zero to 70, and we did
10 that just to be able to show the differential in payment more
11 easily. I wanted to make sure that was pointed out. Other
12 than that, we have largely the same conclusions again, as far
13 as Alaska coming in with higher reimbursement than the other
14 states, so once again, not to the same extent as what we saw
15 in the physician fees.

16 And the third and final of these graphs on the hospital
17 side is just looking at bill charges, and it does show, you
18 know, that Alaska has, on average, higher bill charges than
19 the other states, so not necessarily to the same degree as we
20 were seeing on the allowed charges.

21 Once again though, ultimately, billed charges are of
22 interest when looking at facility reimbursement, but
23 generally, the vast majority of contracts at this point,
24 especially outside of Alaska are based on, typically, a fee
25 schedule type of an approach on the hospital side for some

1 payment that, often times, isn't directly related to bill
2 charges anymore, and certainly, the Medicare reimbursement,
3 itself, is entirely on a fee schedule basis. The billed
4 charges are used with some adjustments, essentially, for
5 outlier payments, et cetera. But in general, the billed
6 charges don't really have much bearing on reimbursement
7 anymore, for the most part, on the facilities side. So I
8 wouldn't put too much weight on these particular numbers as
9 far as any broad conclusions in the analysis.

10 Moving on to slide 23, it's, really, just the same
11 conclusions that we had drawn just now. So I think I'll slide
12 past that.

13 Slide 24. So again, the slides that we saw before were
14 focused on Medicare reimbursement and commercial
15 reimbursement. For the most part, facility reimbursement for
16 VA and TRICARE follows Medicare. So the results that we saw
17 for Medicare are fairly applicable there. The Medicaid
18 schedules vary considerably across states, and because we
19 don't have a relevant data source to measure relative to
20 Medicaid reimbursement, we haven't been able to do anything on
21 a quantitative basis, but we did look -- Alaska and
22 Washington, on the Medicaid side, both have similar per diem
23 type of approaches with Alaska, once again, not surprisingly,
24 having higher reimbursement.

25 A similar statement also to what we had indicated earlier

1 that, within Alaska, the Medicaid schedule actually appears to
2 be slightly higher than Medicare. Again, they're not directly
3 comparable, given that Medicare uses a DRG type approach and
4 pays per case, whereas Alaska is paying on a per diem basis.
5 But it certainly is something, again, that would indicate that
6 Alaska, in general, for Medicare hospital reimbursement is
7 likely higher than the comparison states.

8 And then on Worker's Compensation, there is a number of
9 different approaches for each of the different states that
10 make it fairly difficult to get a comparison of the numbers.
11 In this case, it's actually -- Wyoming, in fact, is the
12 highest reimbursement, given that they pay on a usual and
13 customary type basis in terms of payment, which simply leads
14 to higher reimbursement than a fee schedules approach.

15 So that's our summary on the hospital side. We'll move
16 next into just discussing our future analyses, but before we
17 do that, we wanted to just pause again and see if there any
18 comments on the hospital analysis or any further comments and
19 thoughts from the physician piece.

20 MR. PICKERING: You know, I wanted to add one thing and
21 then we'll open it up for questions. On the commercial-
22 hospital side, the results we presented in the slides were
23 just pure, unadjusted results by any geographic adjustments.
24 We do have another way of looking at commercial, which we'll
25 include in the final report, in which we, essentially,

1 normalize for input cost differences by geographic area, or
2 you know, based on the wage levels and costs of capital in the
3 different geographic locations. We adjust. We divide through
4 by those different factors, such that you can look at
5 commercial allowed payments adjusted for expected geographic
6 cost differences. And while we don't show it in this
7 presentation, what we found is that the Alaska commercial
8 reimbursement is still considerably higher than the other
9 states, even on that geographic adjusted basis, with the
10 exception of Wyoming, I believe. Wyoming, I think, is the
11 highest state on that geographic adjusted basis, but compared
12 to the average of the comparison states, you still see that
13 gap between Alaska facility reimbursement and the comparison
14 states.

15 MR. JHU: So -- and I would add that the geographic
16 adjustment does, somewhat, shrink that differential, since the
17 wages and cost of capital that we use are higher in Alaska
18 than most of those states and areas.

19 COMMISSIONER ERICKSON: Pat?

20 COMMISSIONER BRANCO: I have a question back on slide 21.
21 That one right there. And I'm wondering to what extent the
22 impact of critical access hospitals has on that? We have --
23 over half the hospitals in the state of Alaska are critical
24 access, and they're reimbursed at a higher Medicare rate,
25 101%. I'm wondering if that really does drive that number up

1 a bit?

2 MR. JHU: And just to clarify again, as far as the
3 critical access hospitals, on the inpatient side of things, we
4 have included all hospitals, since that MedPAR data set
5 includes everything, including the facilities that aren't paid
6 on Medicare as inpatient prospective payment system. So it's
7 the outpatient side of things where we wouldn't have the
8 critical access hospitals here now. We haven't looked at it
9 explicitly, and I would guess you're right that, if we
10 included the critical access hospitals, which, typically, have
11 higher reimbursement, I would think that we would be
12 increasing the overall conversion factors and relative costs
13 in Alaska. That being said, it's not quite as extreme, I
14 don't think, as what you had indicated that, although the
15 number of hospitals may be a very high percentage -- you
16 quoted 50% as far as the number of critical access hospitals -
17 - I think a lot of those would tend to be smaller facilities
18 than some of the Anchorage and Fairbanks facilities that we
19 have included in our analysis to date.

20 COMMISSIONER BRANCO: So they are.....

21 MR. JHU: (Indiscernible - simultaneous speaking) 50% of
22 the volume that would be getting added to the analysis.

23 COMMISSIONER BRANCO: They are a smaller volume, but I
24 don't know if this a reimbursement issue or a dollars and
25 sense issue or a critical mass issue of patients.

1 MR. JHU: Sir, can you explain that comment a bit
2 further?

3 COMMISSIONER BRANCO: Sure. I'm just taking your comment
4 that, whether this is based on the fact that over half the
5 hospitals in the state of Alaska are critical access hospitals
6 reimbursed at a higher rate, whether the analysis here is
7 being done on the dollar value of the reimbursement or is it
8 based on the aggregate patient population?

9 MR. JHU: It's being done on a dollar value of
10 reimbursement.

11 COMMISSIONER BRANCO: Oh, okay.

12 COMMISSIONER MORGAN: And I'd like to remind.....

13 MR. JHU: That's my understanding; yeah (affirmative).
14 Essentially, what we have done is we have taken the full
15 claims data set within the state of Alaska -- and again on the
16 inpatient side, that would be all facilities; on the
17 outpatient side, all of the facilities paid under OPPS -- and
18 essentially applied our relative value as to each of the
19 claims and that total red bar or orange bar for Alaska is
20 looking at the total allowed dollars in the state of Alaska
21 divided by the total workload units that we assign to the
22 data. So it would inherently weight these larger facilities
23 more strongly than the smaller facilities.

24 MR. PICKERING: Well, one thing we could easily do would
25 be to look at that slide. So essentially, look at slide 21

1 for critical access versus inpatient prospective payments
2 (indiscernible - voice lowered) hospitals. We have all this
3 by hospital, so it's a matter of rolling it up. So we'll plan
4 on looking at that.

5 COMMISSIONER MORGAN: This is Dave Morgan again. I think
6 the other thing is, when you, basically, look at the data with
7 them in and with them adjusted, if they weren't, that whole
8 set of reimbursement modalities are phased out in the future
9 under the Affordability Care. I believe those type of
10 hospital reimbursement are -- I can't remember when it is. Is
11 it -- it's 2015 or '16, but you might want to just check. I
12 just remember I was at some conference in the last three or
13 four weeks, and maybe our hospital representatives this
14 afternoon can clarify, but I believe that methodology is gone
15 at a certain date, that it leaves the system. I've not been
16 keeping real up-to-date on that stuff, but.....

17 MR. PICKERING: Dave, we couldn't hear everything you
18 said. You were saying the critical access, the cost-based
19 methodology, you thought, was being phased out?

20 COMMISSIONER MORGAN: Well, not the cost-base, but I
21 believe the extra consideration or reimbursement under the
22 Affordability Care Act. It's more of a question, and I could
23 be wrong, but I believe, in future years, that's eventually
24 phased out, but I think we've got some Hospital Association
25 people here. Maybe they can say Dave's wrong this afternoon

1 or Dave's sort of right or we don't even know what he's
2 talking about, so.....

3 MR. JHU: Any comments then from any of the hospital
4 folks?

5 CHAIR HURLBURT: Pat, to go back to your earlier comment
6 where you were kind of nodding, but you didn't say anything,
7 were you suggesting it would be desirable to break up critical
8 access hospitals from the others in that non-Anchorage/non-
9 Fairbanks group?

10 COMMISSIONER BRANCO: That would very useful information
11 for me, in particular. For the Hospital Association, it is a
12 good reference point to have it delineated further.

13 MR. PICKERING: We can do that.

14 CHAIR HURLBURT: And John, just FYI, Pat is the President
15 of the Hospital and Nursing Home Association here this year,
16 so I think he can speak that the hospitals would probably
17 welcome that. Thank you.

18 COMMISSIONER ERICKSON: I think we're ready to go on now.

19 MR. JHU: In which case, looking forward, so slides 23
20 and 24, again, were just a summary of the hospital side of
21 things.

22 Starting on slide 25 then, it's just getting to, again,
23 where we're heading next. A reminder that the methodologies
24 we've used here, you know, we're confident in them. They are
25 somewhat approximate, only, for example, you know, we are

1 looking within the fee schedules of just the top 25 codes by
2 each specialty. In most cases, that got up to 70% or so of
3 the anticipated volume, but certainly, this is not a 100%
4 exhaustive source, such that it's likely -- you know,
5 different people doing the analysis would get slightly
6 different results, but I wager that it's unlikely that anybody
7 would draw substantially different conclusions from what we've
8 gotten to as far as, you know, the Alaska comparison versus
9 the other states.

10 One other piece, as far as the reimbursement, that is
11 always important to keep in mind is that our reimbursement
12 here is comparing reimbursement on a fee-for-service type
13 basis, really looking at what is being paid to either the
14 facilities or to the physicians for the services that were
15 performed. We haven't, at this point, got any analysis as far
16 as the quote/unquote efficiency of the services provided.

17 There has been a lot of discussion of late, you know,
18 including stuff generated from the Affordable Care Act, as far
19 as trying to move the reimbursement system overall to
20 something that encourages more efficient use of services
21 where, right now, essentially as a physician or a facility,
22 the more you do the more you get paid, even if what you're
23 doing is potentially ineffective or unnecessary. I don't
24 think there is, necessarily, accusations out there that
25 doctors and hospitals are doing anything that they deem

1 unnecessary just to try to get the additional reimbursement,
2 but certainly, there's a lot of analysis that's been performed
3 about differences in the relative efficiency providers
4 nationwide and efforts that are currently underway to try to
5 compensate that, or at least, to try to align the compensation
6 incentives together with the ultimate goal of getting patients
7 healthy, as far as the health care system. But it's something
8 we'll look at in the subsequent analyses, but something that's
9 probably, you know, important to have you actually is that our
10 reimbursement analysis here is looking purely at the
11 reimbursement on a fee-for-service type basis and doesn't
12 consider the relative efficiency of providers across states,
13 which leads nicely into the additional analyses that we've
14 been referencing throughout this presentation this morning.

15 Again, the goal is that we'll have our final report --
16 well, we'll have our preliminary draft report on what we
17 presented today by the end of the month, with the goal that
18 we'll have a final report, I believe, sometime in October, and
19 around that same time, we'll also have the preliminary report
20 on this portion here, the additional analyses that we'll
21 really try to look at some of the drivers behind the cost
22 differences that we're seeing and trying to explain them, to
23 the extent that we can.

24 And so on this slide here, slide 26, it just lists some
25 of the things that we're going to be exploring, looking at

1 just comparisons of commercial premium rates across the
2 states, what we're expecting will likely mirror some of the
3 things we've seen, as far as the differences in commercial
4 reimbursement, looking at operating costs and margins for
5 providers, facilities, in particular, to try to see whether or
6 not there are substantial differences in operating costs
7 and/or differences in the margins across states, also looking
8 at surveys of information comparing salaries of health care
9 workers across states.

10 The fourth bullet, length of stay, getting back somewhat
11 to the previous page and the caveat on practice patterns that
12 we can look at the relative length of stay for similar
13 admissions across different states to see how Alaskan
14 providers and facilities compare to other states, analyses of
15 discounts relative to billed charges for commercial
16 reimbursement, and that one there really just to get an idea
17 of the discounts are somewhat an indication of the relative
18 sway and power that the providers have relative to the
19 insurers. Typically in states where the insurers have more
20 pull, you'll end up seeing larger provider discounts, whereas
21 the reverse may be true in states where the relative balance
22 of power falls more towards the providers.

23 And you know, we're still starting up that other
24 analysis, too, so there may be other analyses that we build in
25 as we see fit as we are trying to look through the various

1 aspects of the reimbursement differences to understanding key
2 drivers behind them.

3 COMMISSIONER ERICKSON: Pat and then Keith?

4 COMMISSIONER BRANCO: So there is one that I see is
5 glaringly omitted on here, and by stretching my imagination, I
6 could put it in the operating cost column, but the issue of
7 logistics in this state is really, really vital. The cost of
8 recruiting physicians, specialists, supplies, materials,
9 everything we touch has a logistics component to it that does
10 significantly add to our costs and so I would love to see that
11 in the other analyses, or at least, addressed in the operating
12 cost area.

13 MR. JHU: Thanks, and I think, you know, to the extent --
14 again, the operating cost could be on the facility side of
15 things, but any additional costs that would be incurred by
16 Alaska facilities because of those issues that you've
17 mentioned should be reflected again the in operating costs, as
18 you said, so I guess that should come through there.

19 COMMISSIONER CAMPBELL: Keith Campbell. How are you
20 going to get at the health care salaries, a Ouija board, a
21 crystal ball, or any other method? These are, typically,
22 really hard to get at, and I just wondered if you could
23 divulge your secrets.

24 MR. JHU: (Indiscernible - simultaneous speaking) to a
25 different practice group here at Milliman is -- does extensive

1 work with studies of salaries and total compensation, and a
2 big part of what they do is annual, or typically annual,
3 salary and compensation surveys where they send them out to
4 numerous employers and get responses, compile them back, and
5 distribute the results to those who participated, plus anybody
6 else who is looking to purchase that information.

7 So we've got two surveys. There is one here in the
8 Pacific Northwest that looks, specifically, at health care.
9 Unfortunately, that doesn't cover Alaska. It covers just
10 Washington, Idaho, and Oregon. But then a second survey
11 that's specific to Alaska is a survey of numerous physicians
12 and the salaries and compensations for them in Alaska, which
13 includes a number of health care physicians. And so combining
14 those two studies is what we intend to do to get at the
15 relative salaries and compensations for health care workers in
16 Alaska versus Washington, Oregon, and Idaho.

17 COMMISSIONER ERICKSON: Noah?

18 MR. JHU: Not perfect, in the sense that it's based on
19 self-reported -- or it's based on -- not self -- based on
20 reported salary information from the various employers, but we
21 found, over time, that they're fairly reliable results, and
22 there is a fairly large number of respondents, such that, we
23 think, it will give a good indication as to their salary
24 differentials.

25 COMMISSIONER LAUFER: This is Noah Laufer again. I don't

1 mean to be a wiseacre, but I'm intrigued by the GPCI
2 conversion factor. That's very interesting, to me. Do you
3 have a conversion factor for sort of the real life of
4 recruiting physicians, a conversion factor for convincing your
5 spouse to live in rural Alaska versus Seattle with easy access
6 to everything that's there? I noticed you guys aren't based
7 in Alaska and that's a significant issue, you know. Okay, why
8 should we go to Alaska? How good are the schools? How safe
9 is the community? What about all the dark, far away,
10 thousands of miles away from the grandparents? You know,
11 that's a real factor. I like that we're comparing ourselves
12 to the rural western states because they're our direct
13 competitors as far as recruiting doctors, but even with this
14 differential, we don't seem to have the upper hand as an
15 intangible.

16 MR. JHU: I think that's a good point, and certainly, you
17 know, that's a good place to set the expectations of what our
18 third study is going to do. I don't perceive, at this point,
19 that we're going to come up with something that says, you
20 know, how we've exactly explained everything, but you're
21 right. There are a number of intangibles and a number of
22 other factors that cause people to live in Alaska versus other
23 areas, certainly a difference in people's preferences as far
24 as even, you know, within a state's rural versus urban areas
25 and even more so in the neighborhoods that, obviously in many

1 cases, can't be explained by pure economic or cost factors.
2 So I think that it is going to be an open-ended question even
3 at the end of this analysis is, if we find that the various
4 factors that we're examining and looking at don't fully
5 explain the cost differential, I think that's something that,
6 essentially, comes back to you guys, as a Commission, to
7 figure out, if there is still some left, is that additional
8 amount appropriate in order to fairly compensate the
9 physicians that you're looking for in the facilities to
10 provide the care that you need. So I think your point is
11 well-noted that, certainly, there are a number of intangibles,
12 as you said, that are going to be included in any of our
13 analyses, and I'm not sure -- unless anybody on this call has
14 objections, I don't think there is any true way for us to
15 measure any of that.

16 COMMISSIONER ERICKSON: Val and then Jeff?

17 COMMISSIONER DAVIDSON: So I appreciate that you're going
18 to take a look at some of the sort of geographic factors and
19 logistical factors of rural communities where things have to
20 be shipped in, and sometimes, also shipped out. If you don't
21 have an incinerator that can deal with certain kinds of waste,
22 then that stuff also has to be shipped out as well. But I
23 guess my concern is I want you to -- I hope you can appreciate
24 the geographic expanse of Alaska. I mean, we used to have,
25 what, five time zones because we're so big. So really, you're

1 looking at differentials for the equivalent of five different
2 states, and the reason I bring this up is because I'm
3 concerned about your information in the slide previous, which
4 is how Medicare defines it, that Juneau is not going to give
5 you the same result as Bethel or Barrow or Nome or Kotzebue,
6 et cetera. And you know, I know that Bethel, right now, milk
7 is on sale for \$9 a gallon. I'm pretty sure that Juneau is
8 not paying \$9 a gallon for a gallon of milk, but those are
9 some of the very real costs of -- and I'm not sure what the
10 difference is for what Barrow is paying for milk and what
11 Dillingham is paying for milk, but those things are different
12 and so I would encourage you to look just beyond Juneau or
13 even among the different regions that costs are very
14 different.

15 MR. JHU: We'll give that some thought. I know we've had
16 other analyses in the state of Alaska where we have gone
17 beyond Medicare geographic regions to, you know, split out
18 Southeast Alaska and Kodiak Island just to add some of that.
19 So at least broadly, Medicare's geographic adjustments are
20 intended to reflect a.....

21 COMMISSIONER DAVIDSON: Well -- I'm sorry.

22 MR. JHU:workload rated average of all of the
23 various non-(indiscernible - voice lowered) areas so it would,
24 at least, you know, on average reflect that, but you're right
25 that it might not necessarily show in an analysis Juneau

1 versus some of the other more remote areas outside of
2 Fairbanks and Anchorage.

3 COMMISSIONER DAVIDSON: Well, just to reflect on your
4 comment about Kodiak, Kodiak is cheap compared to the other
5 places. So I would urge you to go beyond Kodiak as well.

6 MR. JHU: Okay.

7 COMMISSIONER ERICKSON: Jeff and then Dave?

8 COMMISSIONER DAVIS: Thank you. Just a couple things.
9 One, back to my earlier questions, I think, when we get to the
10 final analysis, it would be very helpful if we could really
11 show that the true differences in market rates by adjusting or
12 taking out the fact that we are looking at an all payer
13 average, so just a -- well, I mean for that.

14 With respect to data on provider salary or health care
15 worker salaries, I'm not certain of this, but I think that
16 Medical Group Management Association also has data on that.
17 And so you probably know that and have looked at it.

18 A couple of other things to, perhaps, think about when
19 you look at the drivers. One thought is, are there structural
20 things in Alaska law and regulation that may lead to some of
21 this, for example, the determination of UCR, those sorts of
22 things, assignment of benefits, that I would encourage you to
23 also look at. And then there might be other regulations and
24 statutes that may have an impact.

25 And then at some point, perhaps in an appendix, I just,

1 for fun, would like to understand kind of the size of the data
2 set that you use on the provider side, recognizing that, you
3 know, there is no mandatory reporting that you could just get
4 for all of the Alaska data, but using the -- I think it's
5 MarketScan, you know, what kind of representation really was
6 there, and again, we don't need to talk about that now, but
7 I'd like to see that in an appendix at some point or some
8 other time.

9 MR. JHU: Sure.

10 COMMISSIONER DAVIS: Thank you very much.

11 COMMISSIONER MORGAN: Ditto. That's what I was -- but I
12 was looking at my *Alaska Economic Trend* for August 2011, and
13 it's about Alaska health care industry, and they talk about
14 the stuff that you guys are bringing up. I guess community
15 health centers scattered all over the state can really lament
16 the real cost of getting stuff out there and getting stuff
17 back, and more important, getting patients to specialty care
18 from out there and getting them in here, even with
19 telemedicine.

20 I can only relay the experience I had about 12, 11 years
21 ago when I was Operations Director for Eastern Aleutian Tribes
22 in Sand Point. We were going to put a dental -- two dental --
23 operatory -- two seats -- basically, it was identical to what
24 you have here in town up at the end, and basically, we had to
25 bring everything in down to -- I'll never forget it -- a

1 little thing where you just mix stuff, everything. We had to
2 bring everything in. When they said -- when they showed us
3 what it cost to transport and to move all that in Washington
4 State, it was about \$850 on two trucks. I had to hire a
5 specialized transport and the cost of just getting it there,
6 not assembling it, not getting it from the Sand Point
7 International Airport was \$12,500, one-way. Now I do think we
8 probably -- and that was then. I hate to imagine what it is
9 now.

10 I did find it interesting that, yesterday, we were
11 looking at blimps up at UAA. So I just think you maybe need
12 to maybe differentiate in your appendix the cost of getting
13 stuff out there and in, fuel costs possibly, but you're going
14 to have to -- there are some drivers that are outside the
15 control of the health care industry, and in rural parts of the
16 state and even in Fairbanks and Juneau, they have a real heavy
17 burden of cost not only to get providers, but just to get the
18 fuel or the medical supplies out there to do medicine. And I
19 would hope that we would, someplace in there, show that
20 comparison through all those states, so that there is some
21 stuff that we don't control and ditto and ditto and ditto, I
22 guess.

23 MR. JHU: And again, I think, on the facility side of
24 things, that should all come through in the cost reports that
25 are filed with Medicare and are going to be the basis for our

1 analysis stuff. I suspect we'll see all of that coming
2 through there.

3 On the physician side, I'm not sure there is going to be
4 a single unique source that we can use that would actually --
5 there is no equivalent physician reporting requirement to
6 develop all of your global cost stuff.

7 MR. PICKERING: But I think the point is well-taken, and
8 we'll definitely keep that in mind as we're working on this.

9 COMMISSIONER ERICKSON: Keith?

10 COMMISSIONER CAMPBELL: I'm always mindful of unintended
11 consequences, and particularly when we're talking about the
12 salaries and things of this nature. We may have the public's
13 suspicions confirmed, and we may not -- this report may not,
14 in general, have a whole hell of a lot of support for the
15 (indiscernible - voice lowered) in this whole thing because, I
16 suspect, it's going to be -- at least my history says it's
17 going to be fairly high, and inasmuch as the public thinks the
18 people, other than themselves, get paid too much, we better be
19 battening down the hatches for a couple of brick baths.
20 Enough said.

21 MR. JHU: I guess, from our standpoint there, we are --
22 you know, that's we were tasked to do. At the same, if the
23 Commission, as a group, starts to have second thoughts, we are
24 certainly willing to be responsive to whatever you think you
25 need as far as your analysis.

1 COMMISSIONER ERICKSON: Any other questions or comments
2 from the Commission? Well, Ed and John, I don't think we have
3 anything more to add or ask at the moment. I think we're
4 anticipating receiving the complete draft of this phase of the
5 report around the end of next week; is that correct?

6 MR. JHU: Yes.

7 COMMISSIONER ERICKSON: And we do have a subcommittee.
8 I'll just mention for, well, I guess for the sake of our full
9 group here as well as the audience, Pat and Noah and Jeff and
10 Dave and Ward are all on the Milliman Study Subcommittee of
11 the Commission and will be meeting periodically just to have
12 one short meeting, but there was nothing to talk about beyond
13 a little bit about methodology and process at that point, but
14 we'll have a little more in-depth time for review than the
15 full body. And then at the next meeting, we will have not
16 only -- have some time with the draft at that first phase.
17 We'll, at that point, also have the draft of the second phase
18 with the cost drivers and time with either Ed or John or both
19 will actually be in the room with us in person for our October
20 meeting for that conversation. Yes, Noah?

21 COMMISSIONER LAUFER: I know I let my opportunity to
22 speak pass, but the most contentious number as far as
23 reimbursement for physicians, the interventional cardiology
24 number -- you said that this should be taken with a grain of
25 salt -- could we have that in writing because that's the

1 headline that is most contentious, potentially most damaging,
2 and if it is inaccurate or contested or needs to be
3 considered? I'd like that as an asterisk, please.

4 MR. JHU: Certainly in our full report, that is the
5 intent to discuss that and discuss the limitations as far as
6 not just that piece but (indiscernible - simultaneous
7 speaking).

8 COMMISSIONER LAUFER: I think it needs to be more than in
9 the full report because, you know, people don't read full
10 reports and newspapers don't report on full reports. They
11 report on whatever they think is sensational and going to
12 cause a splash, and it needs to be clarified. Thanks.

13 COMMISSIONER ERICKSON: And I just wanted to mention that
14 that was the reason. I'm sure it's frustrating for folks in
15 the audience and on the phone that they don't have a copy of
16 the presentation and we're not posting it on the Web, but
17 because it was a preliminary draft and because of -- we don't
18 -- we want to try to be as responsible as possible with
19 providing this information and so that's why. And to the
20 extent that there are summaries in addition to -- such as the
21 PowerPoint that will accompany the final report, that those
22 sorts of outliers that have caveats can be footnoted, we'll be
23 working, especially -- and I think that's one of the functions
24 of our subcommittee who will be devoting a little more time
25 than the full group, again to help with those sorts of things.

1 So appreciate that. Wes?

2 COMMISSIONER ERICKSON: Wes?

3 COMMISSIONER KELLER: Thanks. I was just wondering if
4 it's okay if we contact John or Ed to get some clarifications
5 individually. Is that included in their scope of work?

6 COMMISSIONER ERICKSON: You probably should work through
7 me and Ward as the Contract Administrators. They're under
8 professional services contract with the State, and we're
9 their.....

10 COMMISSIONER KELLER: Then, as a follow-up, just what
11 level of back up are we going to get as far as the databases
12 and (indiscernible - voice lowered) documents?

13 COMMISSIONER ERICKSON: We'll have full data tables on
14 all of the CPT codes by.....

15 COMMISSIONER KELLER: Thank you.

16 COMMISSIONER ERICKSON:specialty, by payer. It's
17 going to be several reams of paper.

18 CHAIR HURLBURT: The intent would be, if, say, ASTHMA or
19 ASHNHA or a group wanted to really try to look at it and they
20 had concerns, like Noah is expressing, that the data will be
21 there, that they can -- and it will be in an Excel format, so
22 that it can be manipulated by others in looking at it. And
23 John, I don't know if you want to add to that, that we talked
24 about that?

25 MR. PICKERING: No. I think you said it, and certainly,

1 you know, one of our hopes is there is going to be a, you
2 know, one or two-month period from our preliminary draft to
3 the final report. So if anybody has concerns, and certainly,
4 if people find anything that they think ought to be modified in
5 the report -- hopefully if we've got those comments back, and
6 ideally -- thanks, Deb -- I think that would be great, if you
7 or Dr. Hurlburt could serve as the moderator so that we get
8 points that need. Then we'll certainly make every effort to
9 make those adjustments into the final report, so that what
10 goes out as final is something that everyone on this call can
11 be comfortable with.

12 COMMISSIONER ERICKSON: Noah, did you have another
13 question or comment?

14 COMMISSIONER LAUFER: I don't mean to keep reiterating
15 this, but 99.9% of the people are not going to understand this
16 at a deep level and have no desire to. Your disclaimer on
17 page 27 that any user of the data must possess a certain level
18 of expertise in actuarial science and health care modeling, so
19 as not to misrepresent the data, I'm not there, and I'm pretty
20 sure very few people are. It would be disingenuous and
21 dishonest and quite damaging to say, you know, some doctors
22 are billing three times as much and it's that simple. This
23 could jeopardize the legitimacy of the entire process. I've
24 taken off a lot of time of work without being paid. I don't
25 want that to happen.

1 MR. JHU: Okay.

2 COMMISSIONER ERICKSON: Any final questions or comments?
3 Well, Ed and John, thank you very much for your time.

4 MR. JHU: Thanks to all of you for your time and
5 attention.

6 COMMISSIONER ERICKSON: Bye.

7 MR. JHU: Bye.

8 COMMISSIONER ERICKSON: For everybody in the room, we're
9 going to break for lunch right now. And for folks on the
10 phone, we'll be breaking for lunch right now until 12:30. And
11 everyone in the room is welcome to join us for lunch. I would
12 just ask that you let the Commission members grab a little bit
13 of lunch first, so they can eat and be ready for 12:30. We'll
14 reconvene, and we'll have our public hearing period at that
15 point. Any final questions from the Commissioners before we
16 break for lunch? Thank you.

17 11:53:09

18 (Off record)

19 (On record)

20 12:34:16

21 CHAIR HURLBURT: If we could go ahead and get started,
22 we'll move into the public comment period. We have several
23 folks in the room who have signed up for comments, and at
24 least, one online that we have. The folks who are online now,
25 are they on mute or can we hear them? Are the folks online on

1 mute? Yeah (affirmative).

2 COMMISSIONER ERICKSON: I think we're going to have to
3 take a short break and hang up from this teleconference and
4 then tie back in, so that other folks who are on the phone who
5 might want to testify are able to talk because we're in
6 lecture mode right now. We're going to have to hang up to get
7 out of lecture mode.

8 CHAIR HURLBURT: We can't change that?

9 COMMISSIONER ERICKSON: Not through this system, but
10 it'll just take a minute.

11 CHAIR HURLBURT: So they should call back in, Deb?

12 COMMISSIONER ERICKSON: No. They don't have to.

13 CHAIR HURLBURT: They don't have to.

14 COMMISSIONER ERICKSON: I'm sorry. Thanks for
15 clarifying.

16 CHAIR HURLBURT: Yeah (affirmative).

17 COMMISSIONER ERICKSON: Yes. Folks on the phone don't
18 need to hang up, but we're going to hang up on this end, and
19 we'll tie right back in.

20 12:35:42

21 (Off record)

22 (On record)

23 12:36:40

24 CHAIR HURLBURT: We're back up. Hopefully, everybody
25 else is also. We have four folks in the room here signed up

1 for the public comment. Maybe if we can get an idea of how
2 many folks are on the phone? I don't know how to do that in
3 an organized manner so maybe, is there anybody on the phone
4 that has public comment? I think.....

5 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

6 CHAIR HURLBURT: Yeah (affirmative). Brad Whistler, are
7 you on the phone? I'm not hearing anything at this point,
8 so.....

9 COMMISSIONER ERICKSON: We're going to double check to
10 make sure the teleconference is working.

11 CHAIR HURLBURT: Okay.

12 COMMISSIONER ERICKSON: Maralee (ph) has been checking
13 periodically to see if the teleconference is working, and it
14 has been, but we'll double check it right now. Want to just
15 go to the first person?

16 CHAIR HURLBURT: Yeah (affirmative).

17 COMMISSIONER ERICKSON: It sounds like people are -- I
18 mean, we wouldn't hear that noise if folks weren't tying on.
19 Should we start with Jeff Ranf?

20 MR. RANF: Sure. Go right here?

21 CHAIR HURLBURT: Please. Yes. And just press the button
22 on the right side there for the microphone, where the silver
23 buttons, the one to the right.

24 MR. RANF: Right there, is that it? My name is Jeff
25 Ranf. Some of you know me. I've been in the insurance

1 business here in Alaska for the last ten years. I run a
2 company called Wallace Insurance Group. We manage the Alaska
3 Federation of Natives Association Plan. We're approximately
4 70 groups, 70 Native organizations from around the state in
5 that organization, and we also manage and have been working
6 with the Four Acre Group in putting together an association
7 plan for non-profits, and then since the -- then we have
8 invited the State Chamber members into that. That has been
9 kind of a struggle putting together, getting that into a true
10 association type platform, and I'm not going to go into that.

11 But what my comments are going to revolve around are the
12 struggles, as I see it, as we see it in the insurance world,
13 for health care in the state of Alaska, not to mention around
14 the country.

15 In 2003, President Bush put together the consumer-driven
16 health plan in the form of a Health Savings Account type and
17 that legislation went through, and since then, a number of
18 grassroots organizations around the country have really taken
19 that model to heart. The problem that we have in most states
20 -- Alaska, I don't believe, is any exception. I would love to
21 hear from anybody that would disagree with this, but the issue
22 that we have is on the consumerism part of that model. It's
23 very hard to be a consumer in something when you don't have a
24 clue as to what the cost is. The only time that we really
25 realize what the cost of any procedure is -- and I'm not

1 necessarily referring to the primary care model. I'm talking
2 about, if I go into the hospital and I have to have a knee
3 replaced or whatever, I have to do an awful lot of research
4 because the information is not readily available. So my
5 comments are revolving -- and it was a question that I posed
6 at the Commonwealth North meeting last week, and Deb came up
7 to me and said hey, do you want to come and comment at the
8 Commission, and here I am.

9 But the issue that we have is we have no idea -- we have
10 no transparency. I cannot -- unless I do a large amount --
11 and I know where to go look. Unless I do a large amount of
12 research into this procedure that I'm going to have, there are
13 two things that are missing. One is I have no idea what the
14 cost is. The second thing is I don't know if the provider
15 that I'm going to -- I'm not referring to anybody in the state
16 of Alaska, but I don't know if the provider I'm going to is
17 going to give me the best outcome that I'm looking for, and
18 it's going to be cost-effective, not only for me, but for the
19 health plan that I'm participating in.

20 So the issue is that cost items under an employer's
21 balance sheet are listed as, what do I have control over? The
22 one thing that they don't have control over is health care.
23 It's becoming the number two or three cost item on their
24 balance sheet anymore, and we have really no other way to
25 control that, other than through consumer-driven health care

1 in the world. We incent our employees to go out and find the
2 best possible deal that they can find with the best possible
3 outcome that they can find, whether that is in Alaska or
4 wherever it is and that's something that my organization is
5 embarking upon and that is to look to find, where can we
6 create the best kind of transparency for our consumers and
7 then empower our consumers to make the best possible decisions
8 on their behalf and on behalf of the plan that they, the
9 employer, is bringing forth to them?

10 I could comment on this for the next hour, but that's
11 basically what I wanted to put forth. Thank you.

12 CHAIR HURLBURT: Thank you very much, and I think our
13 next presentation will.....

14 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

15 CHAIR HURLBURT:probably warm your heart. Yes,
16 Noah?

17 COMMISSIONER LAUFER: I'm a primary care doc, and I have,
18 actually, the same problem. I have no idea what things cost.
19 I have no idea, when I refer people, what it's going to cost
20 them or what the outcomes will be.

21 But the other question is, who will define the
22 measurement of the outcome? Because when we're talking about
23 health in the broader view, I've said this before, mortality
24 is 100% for us all, but you know, your quality of life. So
25 when things really are consumer-driven, when the consumer pays

1 directly, they often make choices that would surprise people,
2 that do surprise people. So who defines outcome?

3 MR. RANF: There are quality assurance organizations
4 around the country that will go in, and they will measure the
5 outcome of certain procedures. Now, it's not all procedures
6 because, I think, it's very difficult, but they will measure
7 procedures anywhere from getting a meniscus repair all the way
8 up to getting my hip replaced to heart disease to you name it,
9 and they will list all the various clinics in each of the
10 states or just regionally as to which ones have the least
11 amount of infection rate, what's the -- I don't know what the
12 right term is. I'm not a physician, but I've got to come back
13 and have it redone. What's that rate? And they have a lot of
14 different ways to measure that, and if that information is
15 available, which it is, the consumer should have that
16 available to them, so they can say, you know what, the
17 Cleveland clinic might be the best place for me to go for this
18 particular procedure or Providence might be the best place.
19 So that's what I was getting at on the quality assurance side.

20 COMMISSIONER LAUFER: In the realm of medicine of I don't
21 feel good, I'm feeling old, I feel stiff, I hurt, the things
22 that -- I feel fat, often, the choice is to do yoga classes or
23 cut my schedule at work, or these things that, you know, we do
24 a lot of and encourage people, and sometimes, it means I don't
25 get care at all. I don't go to the specialist, and there is a

1 huge cost there, and it's not measured or appreciated or
2 reimbursed.

3 CHAIR HURLBURT: Thank you very much, Jeff. Do we have
4 anybody online now, just so we get a sense? I think it's
5 working. We'll make sure. Going, going, gone. We'll check
6 again before we finish. Now Karen Perdue, I think you're next
7 on the line here from ASHNHA. Welcome.

8 MS. PERDUE: Good afternoon. So I know many of you, but
9 just to let you know, I'm Karen Perdue. I've been involved in
10 health care in Alaska for some time, and I was reflecting
11 today that I've served on several health commissions over the
12 years, went to the State Health Department in 1984 maybe and
13 worked in the Medicaid program, supervised the Medicaid
14 program for many years and then returned as Commissioner for
15 eight years, so worked a lot with the health care system, both
16 the public and the Medicaid system.

17 And I had a couple of comments on the pricing study that
18 I wanted to provide, and they're kind of divided into
19 methodology and then where are we going with the study.

20 So I'd like to start with the methodology issues. There
21 are numerous. Whenever you take on something this
22 complicated, there would be a lot of questions that people who
23 spend their whole life working on this would have that I
24 think, you know, are reasonable, and I think we all want a
25 product that -- you know, the numbers are what they are, but

1 the methodology questions are answered in the process of the
2 draft plan. And we have talked with Dr. Hurlburt about that.

3 As ASHNHA, we offer ourselves up. We have a group of
4 CFOs who are willing to devote some time to reviewing the
5 detailed document and giving their comments, and we'd really
6 like to be able to do that, and we'd like to have enough time
7 to do that in a way that is productive for you.

8 A couple of the things that have come up just this
9 morning and also came up in our discussions in ASHNHA are some
10 of the things, the changes in codes for Medicare between 2007
11 and 2009 and some of the coding questions, the scale of the
12 charts. The 2009 Medicare outpatient only covers four
13 hospitals in the state because it doesn't cover the critical
14 access hospitals, so there are outpatient issues that are kind
15 of methodology issues. And a question that is fairly
16 important is about whether this is a state-to-state comparison
17 or is this a geographic variation comparison within the state.

18 Just right now, you're showing one hospital in Fairbanks
19 and you're comparing that to other states and then you're
20 showing two other regions, and you know, I served on the
21 Fairbanks Memorial Hospital Board for ten years, and I can
22 tell you that those numbers don't compute, for me, based on
23 the financial benchmarking that we've been doing over the many
24 years in the hospital. In other words, it's a community
25 hospital. It tries to track its charges to be not the highest

1 in the state. It tries to track, you know, it's -- it tracks
2 that information, so that information doesn't compute.
3 Perhaps the methodology that's been used is correct, but
4 you're singling out one hospital and you're comparing it to
5 other states just because there is only one hospital in
6 Fairbanks. So those are some methodology questions that I
7 really think are important, and there needs to be enough time
8 to address those with the consultants.

9 Let me just then go on from there to the question of,
10 where are we going? And I was also reflecting on the question
11 of all of the different things that got us to this point,
12 especially in the hospital world, regarding cost, and just to
13 run down some of the things that many of us have been involved
14 in getting, in terms of federal laws.

15 Let's take the critical access hospital program, which
16 came into effect in 1997, and it was done very specifically on
17 the federal government's part to prevent the closure of rural
18 hospitals, and it pays 100% of the costs, plus 1% of hospital
19 costs. So hospital administrators go through a ton of work to
20 prove and justify their costs, a transparent process that's
21 checked and audited, and so we have -- lo and behold, we have
22 100% of costs being paid. News flash: costs are higher and
23 we're paying costs. But that was there for a public policy
24 reason, the public policy reason being small rural hospitals
25 are fairly inefficient by every measure because they don't

1 have a lot of patients, but they provide the service and they
2 provide the (indiscernible - voice lowered) capacity in our
3 communities.

4 Another one would be the GPCI. You know, that was a heck
5 of a fight to get that GPCI adjusted. Thank God for Ted
6 Stevens. He got that GPCI adjustment in the work category.
7 You know, are we now seeing that's a problem?

8 FQHCs, rural health clinics, those federal protections
9 exist. They are cost-based because of the kind of work that
10 those entities are doing. The IHS Medicaid rates. You know,
11 full books could be written about each one of these areas, but
12 you know, the whole interconnection between the IHS rates, the
13 special rates, and the Medicaid and the 100% federal, you
14 know, that's been an evolving thing for almost 30 years, and
15 those costs are higher and they reflect the conditions.

16 So anyway, these things are done by design to create
17 protections for a rural health care system, which is what we
18 have. You know, we only have one community that has -- well,
19 we have two communities that have more than one hospital,
20 Sitka being the other, but virtually, every other community
21 only has a critical access hospital or a sole community
22 hospital. So maybe we ought to benchmark that against the
23 other states and see if there is any other state that has that
24 kind of complexion of those things.

25 You know, we're coming down -- I'll watch my time here.

1 There are coming in federal laws that are quite impactful that
2 we need to be mindful of, DISH -- DISH is going down, a
3 disproportionate share, so that will impact behavioral health
4 delivery of service in Alaska, probably not at API, but at
5 Fairbanks and at Providence for sure, unless they are replaced
6 with state dollars. The ACA contains \$155 billion in cuts in
7 Medicare to hospitals, of which that translates to \$25 million
8 in Alaska, I think by 2019. And MedPAK is looking at the
9 rural construction of a lot of these health care -- of rural
10 protections, and we also know the debt reduction committee is
11 looking at those as well. So a lot of things are on the
12 table, and a lot of these protections that we fought for,
13 which are exhibited in these numbers, are going to be
14 questioned. So you need to be thinking about that in terms of
15 this report and providing some context in the cost drivers
16 about why these things came about, in my mind.

17 And a couple of just specific recommendations that we can
18 pass along to Deb and the consultants about measures to look
19 at, beyond what we're looking at today, and I'll just quickly
20 run through some of them.

21 Bed density. We have a 3.4 bed density in Alaska, and
22 Idaho has a 48.7. North Dakota has a 55.9. So clearly, we
23 have very few beds per 100,000 square miles.

24 The state wage comparisons. You know, health care is a
25 labor business. It's a labor-intensive business, and our

1 state wage comparisons show us about \$20,000 per employee
2 higher than other places. So that's driving the cost. There
3 are also other measures that show the total expense per
4 inpatient day in Alaska showing a fairly similar expense to
5 Oregon and Washington. So there are different ways to look at
6 the numbers, and there are different measures to put in the
7 report that might provide more context.

8 And (indiscernible - voice lowered) for hospitals, bad
9 debt and charity care, which, in Alaska, runs about \$200
10 million, people who cannot pay, but they need the service.
11 And because you're a sole community hospital, you cannot turn
12 anyone away.

13 And then there's the community benefit piece beyond that,
14 that hospitals -- because we've got to be unique in that we do
15 not have local health departments, we don't have a municipal
16 system, except in Anchorage, so whether it's YKHC or Fairbanks
17 Memorial or Seward Medical Center or Ketchikan, those
18 facilities are fulfilling a public health mission, to some
19 degree, in their communities, in other words, the diabetes
20 education or dealing with the Substance Abuse Task Force or
21 whatever those issues are.

22 So those are just comments. God bless you on your job.
23 It's a tough one. I'll be going back to the audience now. So
24 those are my comments, Dr. Hurlburt.

25 CHAIR HURLBURT: Thank you very much, Karen. Thank you

1 for your thoughtful comments. Delisa Culpepper? No. Okay.

2 COMMISSIONER ERICKSON: Jocelyn Pemberton?

3 MS. PEMBERTON: So Dave convinced me to speak.

4 CHAIR HURLBURT: Could you just introduce yourself?

5 MS. PEMBERTON: Yes. So my name is Jocelyn Pemberton,
6 and I am the Administrator for the Hospital List Group, and I
7 also serve as the Legislative Liaison for the Medical Group
8 Management Association in Alaska.

9 So you know, Dave is a member of MGMA, and a lot of
10 questions came up this morning as far as access to data and
11 cost surveys and everything else, and so I just want to put
12 that out there as you are working with that consultant.

13 MGMA does a lot of national surveys for salary
14 comparisons, overhead costs, that sort of thing, and you can
15 drill down to Alaska. And then our association, here locally,
16 does a salary survey as well, not at the physician level but
17 for staff and so that's published every year and so that's
18 good data, I think, for the Commission to review.

19 So my role, mainly, as the Legislative Liaison is to
20 disseminate information to our membership. So I just wanted
21 to sort of plug MGMA a little bit with you all as a group of
22 managers representing a large number of physicians across the
23 state who have the time to sort of respond to any inquiries
24 that you all have might have, when it's a lot more difficult
25 to get a physician to respond. So certainly, please use me

1 for any contact out to the group.

2 And then my other observation, just as an administrator
3 and just a person in this field is, is the Commission looking
4 at cost by diagnosis, and you know, I know, on a hospital
5 level, they certainly look at that a lot, DRG, you know,
6 utilization, consumption.

7 One thing that's come up, as of late, is the critical
8 need for a transitions program in this community. Anchorage
9 doesn't suffer as much from a high admission rate as the
10 Valley does, but a huge (indiscernible - voice lowered) of
11 health care is the patients that transition from hospital-
12 based care out to the community in that gap, in that
13 timeframe. There are long wait lists to get on, you know,
14 with any primary care group, and you know, a lot of the
15 patients that might be suffering from pneumonia also might
16 have a mental health component, a substance abuse component,
17 and they don't have the community supports to transition
18 appropriately out to an outpatient world, so they are coming
19 back in for readmission or using the ED repeatedly.

20 So just to sort of put that bug out there, there is a
21 community effort starting to look at how to develop a
22 transitions program to give this population, you know, be it
23 Medicare, or however those individuals are identified,
24 additional support with case management, with, you know, some
25 (indiscernible - voice lowered) medication reconciliation, and

1 not from a clinical perspective, but more from a social
2 support perspective, but trying to minimize ED utilization and
3 that's ER utilization, and reduce readmission rates. So just
4 so you guys are aware that that's something that's going on.

5 COMMISSIONER LAUFER: I think it might just to clarify,
6 you know, who the hospital lists are. It's a relatively new
7 phenomenon in Anchorage. It started less than ten years ago.
8 Twenty-eight of the docs now, something like that, 27?

9 MS. PEMBERTON: Twenty-six; 19 are hospital lists and
10 seven are (indiscernible - background noise) working in ICU.

11 COMMISSIONER LAUFER: And this has led to a transition
12 for us. I don't, essentially, ever do hospital admissions
13 anymore. We work with you guys a lot and admit patients
14 directly to them. You have a 24-hour presence in both
15 hospitals and very good doctors, and I'm comfortable telling
16 people that they're going to get good care with you guys. I
17 do do social rounds at times, where I go by and reassure them
18 that this new person that they've never met before is, you
19 know, trustworthy, but we rarely have to do that. And this
20 transition out is a huge one because, you know, the pressure
21 is to get people out of the hospital if they don't absolutely
22 need to be there. And so they come stumbling out, and often,
23 have nowhere to go. We'll see them right away, if they come,
24 but an awful lot of people don't, and they end up fumbling
25 around until they end up back in the hospital. But a huge

1 service to our community.

2 MS. PEMBERTON: Yeah (affirmative). I mean, I'll
3 reiterate. You know, our -- part of the problem is in the
4 program, although I think it solved a lot of issues with work-
5 life balance for primary care providers, but when the hospital
6 list program was established -- and our group was established
7 in 2002, but you know, nationwide in the '90s -- you know, how
8 do you transition patients back, and especially medication?
9 That's 49% of readmissions is based on medication errors, and
10 you know, we generally write for 30 days' worth of scripts,
11 but unless you have a patient who is very aware of that or
12 family support to get them back into primary care, you know,
13 we get calls all the time, 35 days later and they have been
14 taking their meds for five days.

15 So you know, I mean, like I said, the community is
16 looking at a way of implementing a transition program, so
17 there are some volunteers or whatever else to go into people's
18 homes and help them transition to outpatient. So I just
19 wanted to introduce myself, mainly. Any other questions?

20 CHAIR HURLBURT: Any other questions or comments? Thank
21 you very much. Appreciate that. Let's see. Do we have one
22 other person here?

23 COMMISSIONER ERICKSON: I don't think so. Do you want to
24 try again to see if Brad's online?

25 CHAIR HURLBURT: Yeah (affirmative). Anybody on the line

1 again? And then we'll come back to you, Dr. Farr. Was there
2 anybody on the line with a comment? Dr. Farr?

3 DR. FARR: (Indiscernible - away from mic)

4 CHAIR HURLBURT: We haven't heard anybody, but tried
5 about three different times. I'm sorry. I apologize that you
6 had to do that.

7 DR. FARR: I'm Dr. Ilona Farr, a family practice here in
8 Anchorage, Alaska, and what I did this morning was I typed up
9 a list of different things that, I think, should be included
10 in the reports and stuff that you guys do and so I will submit
11 that. I didn't have time to Xerox it on the way to the office
12 today.

13 One of the things that came up is these Accountable Care
14 Organizations that are under the ACA bill that I have real
15 concerns about, and there were 344 pages, the regulations that
16 were recently released by the federal government regarding
17 these ACO organizations.

18 There is a really good study that was put out by John
19 Hoff (ph) who used to be the Deputy Director of the Division
20 of Health and Social Services from 2001 to 2005. He has real
21 concerns about this, and I've actually copied this article,
22 and if possible, I'd like to get it around to all of you guys.

23 But the things that really concern me about these
24 organizations as a primary care provider is, A#1, this cost-
25 savings thing. You know, I have fixed overhead and so it's

1 very difficult as a private practice provider for somebody to
2 tell me how much I should charge and also everybody is going
3 to be sharing in the pot here. So how is it going to be
4 equally divided and who is going to decide who gets
5 reimbursed? And if there is a problem with the organization
6 submitting the billing, I could also get penalized, too, and
7 it's something I don't have any control over.

8 There are tons of rules and regulations that are going to
9 really negatively impact those in private practice, and
10 frankly, I could not join one of these ACO organizations
11 because of the rules and regulations. I can't do it because
12 they are going to tell me what I can and cannot communicate
13 with my patients and that scares the heck out of me. You
14 know, you look at -- all of literature that we mail out to our
15 patients has to be reviewed by the ACO, and to me, that's
16 government control over communication with patients. I have
17 real concerns about the actual costs of implementing these. I
18 know the theory is good, but the actual cost I have real
19 problems with because of the administrative burden.

20 So I really think the State needs to look at this in the
21 community and see what we can do to help bring down costs, and
22 I still think Health Savings Accounts are the absolute best
23 way to control costs. If you look at the data from Indiana,
24 67% reduction in outpatient. If you look at the recent Rand
25 data, they had a 30% decrease overall in health care costs.

1 They've done it with Medicare -- I mean, excuse me -- Medicaid
2 patients in some of these states, and they've seen a
3 significant reduction in costs.

4 So I think the first thing that the state of Alaska needs
5 to do is Health Savings Accounts from birth to death for
6 people. Put Medicare and Medicaid patients on it. You know,
7 some of the state laws also interfere with us being able to do
8 these concierge practices or whatever, which, I think, would
9 be really good for physicians in rural areas where they know
10 what their income is on a monthly basis, but yet, by state
11 law, we cannot do that. So that's another I would like to see
12 happen.

13 Again, the state block grants for Medicaid, I think, are
14 important. Reducing the regulatory burdens -- and I don't
15 know what we can do, at a state level, about the double
16 Medicaid and Medicare audits that were under ACA, but if
17 there's anything we can do, that's one of the main reasons why
18 I opted out because audits kill you in primary care, the time
19 and the administrative and everything else.

20 Malpractice reform you need to focus on. Student loans.
21 I was a lifelong Alaskan. I went to the WWAMI program through
22 Alaska State Student Loans. It is one of the things that
23 brought me back to the state. I mean, I would have come back
24 anyway, but it really helped reduce my loan debt. And what's
25 happening now is my daughter is interested in going into

1 medicine. It's going to be \$400,000 for her to graduate from
2 school, if she decides to go to the medical school, which is
3 \$65,000 on average throughout the Lower 48. When you get
4 reimbursed as a primary care provider \$38 for seeing a
5 Medicare patient, there is no way in heck you are ever going
6 to repay those loans. And so what we really need to do is we
7 need to look at loan repayment for people returning to the
8 state, not just paying for education, which I have some
9 concerns about, but actually loan repayment for actual
10 service, and I think that's really good, and I know that's one
11 of the ways the Indian Health Service helps recruit people in
12 the villages. And you know, when I was in Kotzebue, the year
13 after I left, they instituted the loan repayment at Maniilaq
14 which really helped them keep a stable group of physicians
15 there for a long time. So I think Alaska Student Loan Program
16 and Loan Repayment would be good, but again under the ACA
17 bill, the federal government, essentially, took over all the
18 student loan programs and so we need to work with our senators
19 and congressmen to see if we can get an exemption to that.

20 The IPAC Board is going to be a real problem because,
21 again, they are assigning us a value for what our practice
22 costs are, and also the CCER, and you're going to see a lot of
23 physicians close their practices because they don't want to
24 comply with these recommendations. For instance, the
25 mammograms, they still have them at 50. Fifty percent of my

1 breast cancer patients were diagnosed before the age of 50. I
2 cannot comply with those ethically. And so those decisions
3 need to be made at more of a state or a physician level and
4 not by the government because, every place in the United
5 States, we have different cancer rates, different health
6 risks, and so we really need to do something as a state to
7 address that, so we can have a little more autonomy about
8 adjusting physician payments and also costs and care.

9 We need to assess the needs for the aging population and
10 vocational home health. I think that's really, really
11 important to keep our seniors at the home because the longer
12 they are in a home and have people come in that can actually
13 take care of them, it's much less cost for the State, it is
14 much less cost for society, and it's much better for the
15 patient. So I'm really in favor of rural vocational education
16 programs.

17 Preventive care is very important. There is a lot of
18 good studies on prevention of trauma that can really help
19 reduce health care costs, obesity, screening for diseases, but
20 the thing -- here in Alaska, we still have villages that do
21 not have good water, do not have good sewer, and those are
22 things that we really need to continue to look at, and
23 emergency disaster preparedness. And that's one of the ways -
24 - some communities are very well-prepared, but some aren't,
25 but you can lose a lot of people very quickly following a

1 disaster if you don't have food, water, and emergency medical
2 supplies readily available. And you know, if there is a major
3 disaster, like there has been with earthquakes all over the
4 world recently -- I mean, we've gone from having one major
5 earthquake every 66 years to one every seven days throughout
6 the world now. We're on the plate, and we are going to end up
7 with a disaster here, and I think it's really important for
8 all of us to be prepared for it.

9 We also need to increase the WWAMI slots. I think that's
10 very important. There are several students that I know who
11 have parents as physicians here in Anchorage that were not
12 able to get into the WWAMI program, and they are people that
13 would have come back to Alaska, and they are in medical school
14 now. I don't know what's going to happen to them, but I
15 really think that increasing WWAMI slots is going to help.

16 And also one thing that happened with NICE, which is in
17 Britain, very recently was there was -- right now, the NICE
18 board in Britain determines who can and can't get services.
19 If a service exceeds the cost of \$22,000 over six months, they
20 will not pay for it. So there was recently a case of a lady
21 that wanted to pay for her own chemotherapy. It was \$6,000 a
22 month. She wanted to pay out-of-pocket for the service, and
23 NICE board refused her the ability to pay for this. This is a
24 trend in Britain, and now, they passed something where, if
25 you're not at an ideal weight, you cannot get surgery for hip,

1 knee replacements, tonsillectomy. Once you get to your ideal
2 weight, it's an 18-month wait before you can receive those
3 services.

4 So what I want is I actually would like legislation
5 passed here in the state of Alaska so any patient has the
6 freedom to pay for services, if they are capable of being able
7 to do that, and we're not limiting services just because of
8 cost.

9 So that's some of my ideas. I've got a whole bunch more,
10 but I think I'll end there.

11 CHAIR HURLBURT: I think, if you ever leave medical
12 practice, you can be one of these folks on the ads on
13 television that talks fast. So thank you very much for
14 sharing your thoughts.

15 I think just a comment on a couple of things that you
16 said. As you saw, we have a presentation by Professor Harold
17 Miller tomorrow on the Accountable Care Organizations, but I
18 think he will start out by saying he is not talking about
19 these 314 pages of federal regulations. He's talking
20 conceptually about what that is, with a little bit --
21 basically to enhance the physicians' input on control on the
22 system, and I think he'll make that definition. He is not
23 talking about the federal laws that some people feel are
24 making it more difficult.

25 The second thing on your comments as far as loan

1 repayment, about a year-and-a-half ago now, we had good
2 information -- University of North Carolina, I think it was --
3 that absolutely corroborated that, that the quickest payoff
4 and the best bang for your buck, really, in getting the kinds
5 of physicians, especially since you need, like, family
6 medicine, in the places you need is with a loan repayment
7 program. So the Health Care Commission has been supportive of
8 that. We appreciate your comments. Noah, did you have
9 something?

10 COMMISSIONER LAUFER: Thanks for coming over, Ilona. I
11 think the reason she is speaking fast is because she has a
12 stethoscope around her neck, and she is probably knee-deep,
13 and has got three rooms full, and is being paged right now.

14 You said a lot, and I couldn't absorb all of it, but I
15 think an overriding theme -- and not just because we both grew
16 up in Alaska and have a libertarian strain -- is, if you want
17 us to do a good job, get out of the way and let us do it. The
18 more regulation, the more restrictions there are, the more
19 forms to fill out, the worse it's going to get. And if we
20 really want to have a strong primary care, you have to have a
21 strong primary care. You've got to let us be primary care
22 doctors. You need the rotating medical student who sees a
23 primary care doctor to think, wow, you know, she's really
24 enjoying her life. She's doing something meaningful, and I
25 want to do that, not look over the shoulder and see stacks and

1 stacks of unreimbursed, meaningless baloney that you've got to
2 fill out. And you know, this is a plea that's going on and on
3 and on where everyone is talking about it yet. We're passing
4 thousands and thousands of pages of legislation for more
5 onerous restrictions, which do not improve the life of
6 American citizens. If we're really talking about health, you
7 know, get out of the way.

8 DR. FARR: One of the things that's similar to the
9 Accountable Care Organizations was HAN that formed by
10 Providence Hospital, where a group of primary care physicians,
11 they tried to cycle patients through a primary care provider,
12 and they actually did have quite a bit of cost savings, but
13 then it was eliminated because of new legislation that had
14 been passed. So if you guys really want to look at something
15 that was similar to an Accountable Care Organization but
16 wasn't as burdensome, I would recommend that you get the
17 information from Providence about HAN because that was a
18 really good model for up here, and I was really surprised that
19 we ended up having to dismantle it because of new federal
20 laws.

21 CHAIR HURLBURT: What was it? I wasn't familiar with
22 that. What was the name?

23 DR. FARR: It's called HAN, H-A-N, and I can't remember
24 exactly what that stood for, but if you call over and talk to
25 the Administration over at the hospital, I'm sure that they

1 could fill you in on exactly what happened with that, but I
2 know that we got significant cost savings initially with the
3 program, but because of the star clause and stuff like that,
4 it ended up having to be disbanded, but they did really make
5 an effort to try and get people through primary care
6 providers, which, I think, is really good, you know. And I
7 think, in Alaska, we need to have choice. I think we need to
8 have private practice primary care providers, like I am. I
9 think we need to have government facilities, whether it be
10 Indian Health Service, and government-subsidized facilities,
11 and also you can have big corporate facilities, too. But
12 right now, what they're doing is driving those of us in
13 private practice out of business. So anyway, I just -- thank
14 you for listening. I'm sorry I don't have time to listen to
15 all the conference because I'm busy at work, but I wanted to
16 come. So thank you very much.

17 CHAIR HURLBURT: Thank you very much, Dr. Farr, for
18 coming.

19 DR. FARR: Yes.

20 CHAIR HURLBURT: Pat, yeah (affirmative)?

21 COMMISSIONER BRANCO: Thank you very much for your
22 presentation, and like Noah, it was a bit of a fire hose and a
23 lot of really good information, but I really strongly want to
24 endorse the -- your endorsement of the WWAMI program. My
25 hospital has been a direct beneficiary. Two years ago, we

1 doubled the slots to 20. I think this is a terrific program
2 for bringing really valuable physicians back to our
3 communities and so thank you for bringing that up.

4 DR. FARR: Well, I think it's really good, and I think
5 physician extenders and nurse practitioners are wonderful. I
6 worked with health aides and just really appreciated them
7 being able to be my eyes and ears when I worked in the rural
8 areas, but on the other hand, you have to have someone that
9 has a really good knowledge base to be able to manage a lot of
10 different people, too, and that's why primary care providers
11 are absolutely the critical for this whole situation, too.

12 So Deb, is it okay if I give you my email and the summary
13 that I did for my email in the paper and then you can get it
14 to everybody?

15 COMMISSIONER ERICKSON: Absolutely.

16 DR. FARR: Thanks.

17 CHAIR HURLBURT: If we can.....

18 COMMISSIONER ERICKSON: Do you want to try Brad one more
19 time?

20 CHAIR HURLBURT: Is there anybody online now?

21 MR. WHISTLER: Yes, Dr. Hurlburt. This is Brad Whistler.
22 Can you hear me?

23 CHAIR HURLBURT: Brad, could you introduce yourself and
24 go ahead, please?

25 MR. WHISTLER: Thank you. I apologize. I've been

1 online, but I wasn't getting through to jump in. This is Brad
2 Whistler. I'm the Dental Officer with the Department of
3 Health and Social Services and the Division of Public Health,
4 and Dr. Hurlburt invited me today to make a few remarks on
5 water fluoridation as it relates to dental decay and dental
6 costs in Alaska.

7 And community water fluoridation remains the cornerstone
8 for public health interventions at reducing dental decay.
9 Even now that most individuals use fluoridated toothpaste, you
10 still get an additional reduction of about 25% of dental decay
11 in the population with optimal water fluoridation.

12 Nationally, access to water fluoridation has been going
13 up the past decade. The city of San Diego in California is
14 currently implementing fluoridation, and with that, will be
15 very close to approaching what was the Healthy People 2010
16 goals, 75% of the U.S. population with access to optimal
17 fluoride.

18 In Alaska, it's been going the opposite direction. And
19 really, since beginning in 2004 starting in Juneau, in Juneau,
20 we went through a three-year process, and hopefully, that
21 community went off water fluoridation shortly thereafter.
22 Craig, Alaska went off water fluoridation, and most recently
23 in July, the city of Fairbanks went off water fluoridation.

24 So in 2010 for Alaskans that were on a public water
25 supply, we were at about 55% of the population that had access

1 to optimally fluoridated water. With Fairbanks going offline,
2 we will probably be under 50% in 2011. And this has
3 implications for, of course, the dental costs across the whole
4 population, but it also has implications for dental Medicaid
5 expenditures. And there are two state studies that have
6 looked at Medicaid dental claims and comparing fluoridated
7 areas with non-fluoridated areas.

8 The first of those was done in a study that was published
9 in 1999 in Louisiana. It looked at one to five-year olds that
10 were enrolled in the Medicaid program and found a difference
11 of \$36 per child with the higher level of \$36 in non-
12 fluoridated areas of Louisiana.

13 More recently, New York State published a study in 2010
14 that looked at zero to 20-year olds in the Medicaid program,
15 and they found, overall, a difference of higher expenditures
16 in the amount of \$24 per child for the areas of New York that
17 had either no fluoridation or low fluoridation areas.

18 So I just wanted to mention that to the Health Care
19 Commission in terms of a concern, in terms of a factor that's
20 going to influence us down the road in terms of rising dental
21 costs, as we're losing the battle in terms of local support
22 for water fluoridation.

23 CHAIR HURLBURT: Thank you. Pat?

24 COMMISSIONER BRANCO: Thank you for that presentation, or
25 brief presentation. I do have a question about non-public

1 water sources, whether there is a community education vehicle
2 or an assistance in being able to provide a fluoridation
3 system for rainwater collection systems or wells. It's just a
4 curiosity question for me.

5 MR. WHISTLER: Typically, it would be cost-prohibitive on
6 an individual basis to look at fluoridating water. Typically,
7 the answer has been to do fluoride supplements with
8 individuals that are on groundwater sources or water sources
9 without fluoridation. That requires daily drops or daily
10 tablets, and while it's effective, the big problem is with
11 compliance in terms of giving children drops or fluoride
12 tablets everyday.

13 And as I mention children, I just want to also mention
14 that water fluoridation, while most of the studies are around
15 looking at differences in dental decay in children, there is
16 information showing that there is also reductions in dental
17 decay in adults in the population with water fluoridation.

18 CHAIR HURLBURT: We had a delegation of some of the
19 dental public health officers from around the country up here
20 looking at our program, and they came to me with concerns
21 about what's happening in Alaska, that we're losing this,
22 probably the most effective tool that we have to reduce dental
23 caries in kids, and subsequently, in adults. And since one of
24 our charges is prevention, Brad offered to be able to come and
25 talk with us about it because it is a component of health.

1 It's nothing serious for Alaska. Yeah (affirmative), Pat?

2 COMMISSIONER BRANCO: Yeah (affirmative). One more
3 comment right along that line because it isn't just the
4 prevention of caries, dental disease. Caries disease
5 translates into a huge array of other medical conditions down
6 the line. So I think it is the key of preventive medicine, or
7 one component.

8 COMMISSIONER DAVIS: Thank you. Jeff Davis here, Brad.
9 You reminded me of the adage that it's better to sit silently,
10 and when think you a fool, then open your mouth and remove all
11 doubt, but I'll go ahead anyway.

12 Why are cities in Alaska removing fluoridation, can you
13 give us some insight on that, please?

14 MR. WHISTLER: Well, I think it's been different dynamics
15 in different communities. In a couple of the communities,
16 it's been where the local water operator is not supportive or
17 as concerned about water fluoridation and that's really what
18 has led the charge to discontinue fluoridation, but it's not
19 just that dynamic.

20 We're seeing, in the urban areas, there is a national
21 network that's called the Fluoride Action Network, and in
22 Juneau when we went through that, they brought up one of their
23 national spokespeople that gave two seminars there in Juneau
24 around his concerns with water fluoridation. In Fairbanks,
25 when Fairbanks went to the task force, we saw a site that was

1 brought up with the assistance of that network within days in
2 terms of, I think it was, Fluoride-Free Fairbanks.

3 And so there is an organized effort that's going on in
4 the urban areas of the state to question the safety of water
5 fluoridation, despite, at this point, 60 years of studies that
6 have looked at various aspects of water fluoridation, but
7 we're also seeing it, even with elected officials and public
8 employees that are, you know -- part of it is a generational
9 thing.

10 I think that, typically, older groups that kind of
11 remember maybe a little bit more what dental decay was like
12 before fluoridation or went through that dynamic and the
13 politics of when we started fluoridation are more supportive
14 of fluoridation, whereas younger groups really haven't heard
15 much about it. And so some of it is an awareness knowledge.
16 Some of it is people think, well, we have fluoridated
17 toothpaste now; we don't need water fluoridation anymore.

18 So it's a mix of different approaches. The opposition
19 approach in the urban areas (indiscernible - background noise)
20 question the safety of water fluoridation with bringing up a
21 variety of issues in terms of trying to scare the public away
22 from water fluoridation.

23 COMMISSIONER DAVIS: Thank you very much.

24 CHAIR HURLBURT: Any other comments or questions? Brad,
25 thank you very much. I know you're in a meeting there, but I

1 appreciate your willingness to call in.

2 MR. WHISTLER: I appreciate the opportunity to make a few
3 comments.

4 CHAIR HURLBURT: We do have one other individual.....

5 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

6 CHAIR HURLBURT: So we better.....

7 COMMISSIONER ERICKSON: Brenda is in the room.

8 CHAIR HURLBURT: Thank you, Brad.

9 MR. WHISTLER: Thank you.

10 CHAIR HURLBURT: Brenda Moore?

11 UNIDENTIFIED MALE: Hello? Hello?

12 CHAIR HURLBURT: We'll come back to you. We've got
13 another comment here in the room and then we'll come back to
14 you. Brenda, if you could introduce yourself?

15 MS. MOORE: Hi, I'm Brenda Moore, and I am with Christian
16 Health Associates. We have, under our -- we're a non-profit
17 organization. We have, under our umbrella, Cornerstone Clinic
18 Medical and Counseling Center, Alaska Medical Missions,
19 Anchorage Project Access, school-based health center, and our
20 faith-based in-community relations.

21 I'm just wanting to bring you -- to give you a heads-up.
22 Dr. Perkins, Byron Perkins, who is our Medical Director for
23 Cornerstone Clinic is an osteopathic physician and has
24 recently become the Regional Dean for Pacific Northwest
25 Washington University, which trains osteopathic physicians.

1 Currently, we have 24 Alaskans who are in that program, and
2 we're trying to work with the family practice residency
3 program and others to make opportunities for these students to
4 come back and do residency programs.

5 Pacific Northwest University has a focus on rural health,
6 and just some statistics: About two-and-a-half times more
7 osteopathic-trained doctors go into family practice than do
8 allopathic, and many more of them practice in rural settings
9 than do their allopathic counterparts. So we're wanting to
10 work with the Health Workforce Development to incorporate
11 these students that are in the pipeline to get them residency
12 placements and back into Alaska to practice.

13 CHAIR HURLBURT: Great. Thank you very much, and I think
14 I would just echo what you say that, where we see in some of
15 the allopathic schools -- I understand Harvard dropped their
16 primary care program -- that the osteopathic schools have been
17 doing a much better job of getting their graduates into
18 primary care. Hopefully, the allopathic schools will come
19 back to that because, as we've discussed, that's a real need.
20 So appreciate your comments.

21 I think we have one or two other people online. Is there
22 somebody online?

23 DR. MAKIN: Hello?

24 CHAIR HURLBURT: Could you introduce yourself?

25 DR. MAKIN: Yeah (affirmative). This is Dr. Makin, and

1 I'm an Internal Medicine Specialist in Anchorage. And I've
2 been in Anchorage for the past 25 or 26 years.

3 I just had a quick comment on -- hello?

4 CHAIR HURLBURT: You're still on.

5 DR. MAKIN: Okay. I have a quick question on the ACOs
6 and a couple of comments. The Secretary of the Health and
7 Human Services says that this is a new model. Perhaps, she
8 wasn't around to feel the brunt of the HMOs in the 1980s. So
9 if somebody could clarify how this ACO model would be
10 different from the HMO model of the '80s -- as far as I --
11 from my reading of it, I don't think there will be any
12 difference at all.

13 Like the HMO model, there is going to be dumping of sick
14 patients. They'll be denial of procedures and investigative
15 studies and expensive treatments in the name of cost savings.
16 After all, it's going to be the provider who will bear the
17 penalties for poor results, and do the physicians have control
18 over what these patients do after they go home? Are we going
19 to be hiring more people to make calls and see if they are
20 taking their medications, they are checking their blood sugars
21 at home? Are they keeping their specialty appointments or
22 going for physical therapy?

23 The pay-for-performance is flawed in its concept. It
24 (indiscernible - voice lowered). It forces doctors to make
25 decisions while they are looking into their wallets. The

1 results of this are known from the previous HMO experience of
2 the 1980s. I trained in Detroit and that, literally,
3 destroyed private practice. The HMO model, ultimately, failed
4 miserably, but not until it had caused enough harm. The
5 consumers got fed up with the system and sued the HMOs for
6 denied care, and of course, finally, after many, many years
7 decided that the HMO are liable -- and liable as the providers
8 in denying care.

9 The HMO model was a pay-for-performance, and it's no
10 different than the proposed ACO model. The only difference is
11 that the highly paid HMO CEOs are going to be replaced by some
12 hospital administrators or their bogus alliances with some
13 insurance company. I mean, the United Health Care and Humana
14 and AETNA CEOs, we know their salaries ran into eight figures,
15 at whose cost? You know, ultimately, it's the patient that
16 gets denied the care.

17 And you know, this meaningful use of EMRs is another
18 question, is this being enforced to collect data on the
19 physicians and their performance? And then there are
20 penalties for not prescribing medications electronically; is
21 that unlawful? And it is likely to be challenged in court. I
22 mean, you can't make people use technology, if they don't want
23 to use it. You know, if the ACOs are just going to take care
24 of Medicare and Medicaid patients, who makes sure that these
25 patients are going to be compliant?

1 All of us know that the Medicare patients don't keep
2 their appointments, but they still access the emergency room.
3 I mean, they're saying that the ACOs are going to be
4 voluntary, but it looks like it's the law. You know, the art
5 of medicine is going to be replaced by standardization, and
6 the standardization, you know, can be boiled down to the
7 desire by the employers and the government to create the so-
8 called Accountable Care Organizations in the belief that
9 better organized standard care will deliver better care, and
10 their financial penalties are the rewards for outcomes. I
11 mean, finally, it's the provider that bears the brunt of the
12 bad outcomes.

13 CHAIR HURLBURT: I appreciate your comments. We do have
14 -- Dr. Makin, we have a presentation tomorrow on ACOs. It's
15 certainly something that's being talked about a lot, and the
16 intent is that the Commission members become more aware and
17 more knowledgeable about ACOs. As I mentioned earlier -- I
18 don't know if you heard it -- I know the intent of the
19 presenter will be to talk about some of the concepts of it,
20 which seem quite at variance with some of the federal proposed
21 legislation, which has been met with fairly universal dismay,
22 I think, and I'm sure that wasn't the intent on the part of
23 the Feds. So maybe we're in an evolving process there. Noah,
24 did you have a comment?

25 COMMISSIONER LAUFER: I agree completely. I think it's,

1 ultimately, failed and going to fail in many ways. The
2 question, for us, is, how fast will it fail because this isn't
3 something I'm dallying in. This is my life and my calling,
4 and well-meaning people, well-meaning or not, can destroy
5 that, and this is incredibly serious to us and to our
6 patients. It's being played with in town. I don't even see
7 it as a meaningful attempt to make things better. It's a way
8 to maintain territory or increase it, or you know, it's
9 competitiveness. It's the same deal. It's -- you know, you
10 use federal regulation and lobbyists to gain an unfair
11 competitive advantage, outsource your -- or excuse me --
12 externalize your costs, or get free federal dollars and that's
13 what's wrong with the country. We do not need to, and should
14 not, participate.

15 CHAIR HURLBURT: Thank you. Any other comments? I think
16 there is one other person online, is there, with public
17 comment? Anybody else online with a public comment? I guess
18 not. So we're.....

19 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

20 CHAIR HURLBURT: Anybody else in the room? Yes? Maybe
21 I'll ask you to be brief because we're at the end of our time,
22 but appreciate it if you could introduce yourself and who you
23 represent, please?

24 MS. PEREYEA: Sure. I'm Amelie Peryea. I'm a fourth-year
25 University of Washington medical student. I'm not an Alaska

1 student. I'm from Eastern Washington, rural Washington State.
2 And what I wanted to say is just, don't forget about the
3 University of Washington medical students who aren't from
4 Alaska. There really are enough opportunities for us here,
5 just to learn about Alaska. I'm thinking about working here
6 because I did a third-year rotation up in Nome, which has
7 since been eliminated, and had this wonderful opportunity to
8 be introduced to the state and kind of make it a part of my
9 identity and that's what keeps bringing me back. And now I've
10 been here for two more rotations, despite not knowing anything
11 about the state prior to this last year.

12 So I strongly encourage all of you to support other
13 educational opportunities, including residency programs,
14 because there is only family medicine here, and I'm not going
15 to be a family doctor. I'm doing obstetrics and gynecology,
16 but there is no opportunity for me to train here after my
17 fourth year. So that may prevent me coming back, you know,
18 unfortunately. So that's really all I wanted to say. Thank
19 you.

20 CHAIR HURLBURT: Thank you very much. Appreciate that.
21 Any other comments? We're over time. Yeah (affirmative).
22 But David, please?

23 COMMISSIONER MORGAN: In defense of HMOs and some forms
24 of ACOs, I think a lot of what you're saying is true, but
25 there also have been some HMO models that are closer to North

1 Carolina that we were lectured on. I work for -- that was my
2 first job out of the Army off the boat from Vietnam was
3 working as a staff accountant at a co-op, an agricultural co-
4 op that formed their own HMO in 1905. It's still there, has
5 20,000 members.

6 Those farmers could not, in central and southeastern
7 Kentucky, get physicians or hospitals and stuff. So through
8 the Grange, on their utility bills and water bills, they paid
9 five or ten dollars, in the beginning, a month, so they could
10 have a doctor and a visiting nurse and a small five-bed
11 hospital, much like rural Alaska. It worked, but it was
12 owned. The board was elected by the members that used it, and
13 even when that HMO got up to 25,000-30,000 members and was
14 certified, fairly certified, they -- except out of the 13-
15 member board, 12 were elected from the membership on staggered
16 terms, like a school board. That model, just like North
17 Carolina, seemed to work very well. So there are exceptions
18 to the rule. I think a lot of people, I think, would say
19 Kaiser is a good program that works well, but it's -- well,
20 but at least, you don't hear the complaints. So they probably
21 have more of a, you know, co-op type mentality. I'll bet you
22 a lot of their board is elected by the people that use it.
23 That's why I always felt very comfortable in the Indian Health
24 process because everyone that uses the system elects our
25 boards. It's sort of that way.

1 When you have the people that use it elect the board, it
2 seems to bring a more reasonable approach to how this stuff is
3 run, and believe it or not, a very conservative one wanting to
4 do things to save money because they own it. So you know, in
5 some ways, yes; there is a lot of problems. We answered those
6 regs with a 35-page letter, ACO regs. We weren't too tickled
7 about it either. So I understand and I appreciate, but on the
8 other hand, we should -- whatever tools we've got that we
9 think will work, we should work, and the ones that don't, I do
10 agree we shouldn't. That's all.

11 CHAIR HURLBURT: I think tomorrow, we'll have some chance
12 to hear an interesting presentation. I haven't met Professor
13 Miller. Deb has talked with him on the phone. He talks a lot
14 around the country about this. I think it will be an
15 interesting presentation for us. We probably should move on
16 now.

17 Our next session, there are some readings in here that
18 Deb provided for everybody. If you've not had a chance to
19 look through those, I would urge you to do so, but we're
20 talking about price and quality transparency. That's one of
21 the things that we've mentioned frequently in the Health Care
22 Commission here. Deb, if I could turn it to you to introduce
23 Denise Love, I think you have the information that was just
24 handed out.

25 COMMISSIONER ERICKSON: Yes. Please, Denise, if you

1 wouldn't mind? And is it okay, would you mind if I operate
2 your slides for you up here? Okay. Thanks. At no charge.

3 Well, I'm very happy to welcome Denise here. She's
4 traveled up from Utah to be with us today, except she has --
5 you've lived in Alaska before, at least for a brief time, I
6 believe; is that correct?

7 MS. LOVE: If you count summers in McKinley in the early
8 '70s.

9 COMMISSIONER ERICKSON: We had a connection because
10 that's how I came to Alaska, right out of college working at
11 the Park for the summer. So we bonded right away, as soon as
12 we figured that out.

13 But again, I'm pleased to introduced Denise. She's the
14 Executive Director of the National Association of Health Data
15 Organizations and is a nurse by training and has a Master's in
16 Business Administration in Health Care Administration,
17 specifically, but has worked for decades now with health data,
18 using health data for improving health care and health,
19 starting out in public health, I believe. I don't see
20 anything in your bio about early years.

21 MS. LOVE: I have a checkered past. I've been in the
22 clinical care. It was Blue Cross and HMO administration,
23 ironically, that sort of got me on the path to the data, and I
24 got drafted to Utah's form of a Health Care Commission, the
25 Utah Health Data Committee, in 1991, which started by data

1 policy experience. Nine years in Utah, but I now, for the
2 last decade, have worked with other states, and thus, bringing
3 me here today.

4 So I'm acutely aware that I'm talking data after lunch,
5 after a long day. So you know, I'll try to hit the high spots
6 and then come back to things that might interest you more
7 because you do have a lot on your plate here. Yes?

8 COMMISSIONER ERICKSON: For folks who are on the phone,
9 Denise's presentation is loaded on the Commission's website on
10 the August meeting page, and there are copies of it in the
11 back of the room for folks in the audience. And for
12 Commission members, it should be behind tab four in your
13 notebook, but it's in your extra handout packet you got this
14 morning. So if you didn't put your extra handouts in your
15 notebook yet, you'll find it there. So I just wanted to
16 mention that for everybody.

17 MS. LOVE: So I think what I'm doing today is giving an
18 overview of what other states are doing and what the terrain
19 looks like as far as data and data infrastructure, health
20 information in other states. And sometimes what I've learned
21 is hearing about other states helps you all shape your
22 thinking about what might work or not work for Alaska. We
23 have a saying at NAHDO that you've seen one state, you've seen
24 one state. However, when it comes to data, data aggregation,
25 data use, the problems are common. The solutions sometimes

1 are as well. So go ahead.

2 A little bit about NAHDO. The National Association of
3 Health Data Organizations was founded in 1986, and it was
4 formed, primarily a spinoff of the Washington Business Group
5 on Health because employers were experiencing double-digit
6 increases in health care costs and wanted information and all
7 of the value purchasing sort of initiatives that came about in
8 the '80s, and they found out that 25 states were collecting
9 some form of hospital discharge data. So they brought those
10 states together and NAHDO was born, and the states, ever since
11 then, have been working with each other to promote the
12 uniformity and comparability of the data they collect, promote
13 that data to be used for market and policy uses, and
14 facilitate its distribution and use while, at the same time,
15 assuring and protecting patient privacy.

16 So just a little capsule story why I became so
17 impassioned about NAHDO is that I was newly-appointed in the
18 state of Utah when there was quite a brew-ha-ha about the
19 hospital discharge data reporting laws and rules, and it was
20 quite controversial then. The terrain has shifted, of course,
21 but who helped a lot were the other states that had already
22 implemented, and they helped NAHDO with their roadmap, and I
23 think that was a powerful tool and so I've pretty much
24 committed the next 20 years to doing the same with other
25 states. Next slide.

1 This is founder Willis Goldbeck, and I like this slide
2 because, in 1985, he was the one talking about variation,
3 volume, damages in terms of morbidity and mortality, and
4 social disparities even then, and with the data that we've
5 compiled and that members use, we know that these are real
6 issues and the data can support some of the interventions.
7 Next slide.

8 So what we do at NAHDO is we advocate for data policies
9 that are workable and practical. We do work in the national
10 standards arena, quite a bit of standards work, and I'll touch
11 on that, but not very much today. Technical assistance we do
12 provide to states, including Alaska, as needed, and promoting,
13 again, the data for a broad range of users.

14 So I'll go over briefly hospital discharge databases. I
15 know a lot about them, but I'm not going to spend a lot of
16 time talking about them because, I think, people know what
17 they are, and a new kind of database I'll spend a little more
18 time on because I think, given the last presentation, this
19 might be of interest to you folks and how they're used and the
20 lessons learned.

21 This is kind of a crude map or depiction of a statewide
22 data system as most states are developing them today. I think
23 Alaska would be the top-half of the window, where you have the
24 discharge data from institutional providers or most
25 institutional providers flowing some standard edits and put

1 into a data aggregation or warehouse for types of use.

2 The second kind of data system that we're spending a lot
3 of time on around NAHDO is all payer claims databases, which I
4 will talk about, which is a different kind of data set that's
5 a little more complex, but it works in tandem beautifully with
6 the hospital discharge database, and when put together, you
7 can really have a pretty good window into the health care
8 system and its performance.

9 So let's just breeze over hospital discharge databases.
10 This is my map, and I think North Dakota is white now, so I'll
11 just say that right up front. They had data and then they
12 stopped funding it and stopped collecting it and so they are
13 somewhere in between.

14 But as you can see, we've spent a lot of time coloring in
15 this map. The yellow states are the mandates states, states
16 that have some form of legislative mandate that says that all
17 providers in a class will provide data to an agency and that
18 agency could be a state agency. It could be a non-profit
19 board that is designated or delegated authority or even a
20 hospital association that operates the mandate on behalf of
21 the state.

22 The orange states are those that have no state mandate,
23 but the hospital association or -- and in those, it is a
24 hospital association that voluntarily collects -- and Alaska
25 is one of those -- and aggregates the data voluntarily from

1 either member hospitals or all state providers. The problem
2 with the voluntary, like the Montana and Alaska, there may be
3 some missing pieces because there is no compelling law that
4 makes the providers participate, but it works well in some
5 states where the providers see the utility and they get
6 something back. So we don't really take a position which is
7 better. They just have different methods of operating.

8 This is a study NAHDO did with NORC and AHRQ, and I don't
9 know that I want to belabor it, but the hospital discharge
10 databases, in short, are the workforces for the state and
11 research and federal government. They're where a lot of the
12 market share analyses are going on, quality improvement,
13 quality studies, public safety, disease surveillance and
14 outcomes, and consumer information. They aren't perfect.
15 They have some holes, and I have whole afternoons that I can
16 devote to talking about the limitations and the strengths, but
17 if you go to the next slide, I'll save that and we'll just
18 talk about they have huge strengths because it is a full
19 census of acute care patients.

20 They are comparable state-to-state and fairly comparable
21 across providers with some caveats. They are available data.
22 It's not data that has to be abstracted, nor does it have to
23 surveyed or collected. It does represent the sickest, highest
24 cost patients in a state, and it does have robust diagnostic
25 procedure information for the applications they are used for.

1 It's not a clinical outcomes database. Again, it does have
2 payment information. It has charge information and line item
3 detail. Physician information is limited in there, as is
4 outpatient is missing. Again, no lab results, and coding
5 practices do vary, and we have to take that into account when
6 it's being used.

7 So what's the new kind of database that sort of caught me
8 off guard, but it's been taking off -- and this is where I
9 spent a great deal of my working time. In conjunction with --
10 you can go to the next slide.

11 NAHDO has joined with the APCD Council, and this is a
12 group out of the Institute for Health Policy and Practice at
13 University of New Hampshire. The National Association of
14 Health Data Organizations have joined together with states and
15 formed the Council, and we're working, at first, with the
16 northeast states that were the early adopters of APCDs, but
17 then NAHDO came in with the other states, and our members were
18 saying, you know, we're going to do this in Utah. We're going
19 to do this in Oregon. So it became more the APCD Council than
20 a northeast sort of initiative. Next slide.

21 Well, you know, we've talked about this all morning, so I
22 don't have to tell you that there just this huge push for
23 transparency, payment reform, ACOs, the HITECH Act, OCHA (ph).
24 Just states are, I think, feeling a little -- and I think the
25 last conversation was clear that you're not alone. States are

1 feeling under siege, and they have to do something, but what
2 is that something? And whatever intervention you take, how do
3 you know it's going work? And you know, who is getting hurt
4 and by how much? So it really is fueled by, what is our
5 dashboard? Hospital data are great, and some of the other
6 things, but it doesn't tell us what we need to know as we go
7 forward with these challenges ahead.

8 So what do I mean by an all payer claims database? Just
9 for the record, this is our definition that we've added with
10 the states. These are large scale databases, typically
11 created by a state mandate. They include medical, pharmacy,
12 dental claims, along with eligibility and provider files from
13 both public and private payers. The submitters are insurance
14 carriers, mental, dental, TPAs, and PBMs. Medicaid and
15 Medicare are in the roadmap for most of the states, and we'll
16 talk about how that's going. And I want to make a case -- and
17 I think one of the papers does as well -- that I tell states
18 this does not replace your hospital reporting. They are two
19 different streams built for different reasons, but together,
20 they can work nicely, and some states have put those together.
21 But again, they do not replace other registries or any other
22 data flow. These are a new kind of data set.

23 These are questions. These are just example questions,
24 but one thing that's missing here is, I think, I'm excited
25 about them because it really is consumer information. I'm

1 just so impressed with some of the states now that can put out
2 consumer prices on the Internet and what their expected out-
3 of-pocket is, what their, you know, insurance company will
4 pay, and to look at the variation.

5 And one of my favorite slides is not here, but I showed
6 it to legislators last December in Phoenix, and you know, it's
7 one state -- I think it was Maine -- in the variation in
8 colonoscopy because, those of us of a certain age, we do think
9 about these things, and you know, when I had to make my
10 colonoscopy decision, it was kind of random, but I look at a
11 chart that you can get on the main health cost website, and it
12 shows this huge variation between providers and the highest
13 and the lowest costs for a colonoscopy. And you know, I like
14 to ask groups rhetorically, what do you get, you know, for
15 \$2,000 more or \$3,000 more? I mean, it's the same procedure,
16 but it does sensitize consumers, especially consumers that are
17 paying more out-of-pocket, that there is a variation and there
18 may not be that much difference in some procedures and
19 outcomes.

20 So these are just some example questions, and I won't
21 belabor them. We can come back to them, if you'd like.

22 So what's the terrain now? Well, we fill in maps, and
23 the gray states, like Alaska, are states that haven't, to this
24 date, had any all payer claims database initiatives. The
25 states in the lighter blue are states that have some form of

1 legislation or planning committee or we've been on the ground
2 working with the governor's commissions around some form of
3 all payer claims database initiative.

4 The dark blue states are states that are actively
5 implementing, but not yet have a full-on data set, and the
6 really dark blue states, Utah, Kansas, Minnesota, Tennessee,
7 all the Northeast states, and Maryland, have full-on
8 collection and use of all payer claims databases. I think
9 Oregon is pretty close to being dark blue.

10 And I think there are a couple other states that we've
11 contacted, but anyway, this is it as of about two months ago.
12 So there is quite a bit of interest in these states. The
13 Northeast states are the leaders because they have been
14 collecting and using the data since about 2003 starting in
15 Maine. So they have the most history, longitudinal data, and
16 their applications are starting to be generated out of the
17 Northeast states that NAHDO has helped propagating to others.

18 The light blue states, Wisconsin and Washington, are
19 interesting because these are voluntary initiatives that
20 started with some employer coalitions, some employer groups
21 that have really been blossoming as voluntary efforts without
22 state mandate.

23 Wisconsin is impressive, and they've gotten, I think,
24 Medicaid now rolled into their multi-payer commercial claims.
25 I think they're in line, if they have not gotten Medicare

1 data. The problem is it is some payer-driven, so they aren't
2 getting a paid amount. I mean, without this little thing
3 called legislation, you can go pretty far, but you might not
4 be able to go as far as you want. So that's just -- those are
5 the light blue states.

6 We can answer questions later, if you have anything about
7 them, but so are the states doing this? This is our roadmap,
8 and this is -- we wrote for the Commonwealth Fund sort of a
9 proven, tried and true roadmap that we have seen states that
10 follow pretty much these step-wise activities that they can
11 get to where they want to go, if they have funding.

12 Now funding is my biggest problem because initial funding
13 and sustainable funding is dicey because my lesson learned in
14 20 years of data policy is everybody wants it and nobody wants
15 to pay for it, but once it's built, it has tremendous value,
16 and somehow, things get put together so that data system can
17 live, but it's a tough sell on the front end because, you
18 know, it's still abstract and people are still not sure who is
19 going to benefit and how much it's going to cost. So I think
20 that one box of funding is my biggest challenge, especially
21 since there is no federal dollars directly that go to these
22 databases. But we have learned that you can't do this unless
23 all the stakeholders are at the table because one of the
24 things that we do -- with data policy and community databases,
25 one of the fundamental principles that I've learned is, if

1 it's not built with stakeholder support and for users and for
2 the people on the ground, it's not going to get very far.
3 Everybody kind of has to have their say, and it's a tough
4 sell, but again, the stakeholders have to be part of that
5 conversation, or sometimes, it gets torpedoed. We know how to
6 get rules in place. We have a whole -- on the APCD Council
7 side -- I'll have the website address at the end -- all the
8 rules are out there, all the collection rules, submittal
9 manuals, everything we know. We wrote a piece on technical
10 build. We know some of those decisions and can roadmap
11 through that.

12 Analysis and application, I want to say those, and we
13 talked about measures a little bit. What are the measures you
14 want? Those measures will evolve, and they're starting to
15 take off as we see more uses and users of the data, and I'll
16 show some examples.

17 So what's in the database? Well, this is like peeling an
18 onion, and so the outside is where we start because you cannot
19 -- even if Alaska wanted to do this tomorrow, you couldn't put
20 all the data in the pot and make it work at once. So the
21 typical pathway for a state is begin with the commercial.
22 That includes TPAs and Pharmacy Benefit Managers, and in most
23 states, dental as well, and incidentally, you get Medicare
24 Parts C and D through some of these Medicare Advantage, you
25 know, plans that carry that, but the commercial is the logical

1 place to start, but it's a difficult undertaking. So you have
2 to solve that first.

3 States will have to access their market, how many payers,
4 how many platforms does that represent because that's the
5 driver of the cost. And in this state, there may not be that
6 many platforms and insurers, but again, those are decisions
7 that have to be made locally. And then, what thresholds? You
8 can't go after mom-and-pop TPA. It's not worth it. You know,
9 where is the material starting place as a threshold?
10 Maryland, for instance, has premiums over a \$1 million of
11 business. Other states have decided it's \$5,000
12 (indiscernible - voice lowered). So you know, we work with
13 the state to get the critical mass to start with, normalize
14 that database. Once they solve the commercial and can
15 aggregate the commercial pieces, the progression is to
16 Medicaid. And if they're lucky, they don't have too much
17 Medicaid managed care, but that doesn't mean managed care is
18 off the hook. It just means that the fee-for-service is
19 easier. And then you have to back into, where are the data
20 for managed care? Is it truly carved out as an encounter
21 data? And so those are -- some states have a bigger problem
22 than others.

23 Well, all the states plan to get Medicare, and we've had
24 a lot of activity. I've had more interaction with Congress
25 and CMS in the last few years than I have in all the other

1 years combined since I started with NAHDO, and this is around
2 the Medicare access for data. There is some recent
3 legislation we just responded to, but states are getting
4 Medicare Parts A and B.

5 For Alaska, this may be the hardest sell is that middle
6 part, the core of the onion or whatever you want to call it.
7 We go into this telling states off the table in the beginning
8 is the uninsured because there are no transactions for the
9 uninsured yet. We think we know how to do it, but it's not a
10 starting place. TRICARE we've had some talks with, and I
11 think, down the road, there may be some possibilities that
12 TRICARE will play ball, but I can't promise. It's just that
13 it's going to take some work. And VA is another one that we
14 aren't getting across the states. There may be some local
15 conversations going on to voluntarily get that data. Indian
16 Health Service is another missing piece, and federal employee
17 health benefits. Those are ones that states want to look and
18 eventually get, but their hands are full on the other ones,
19 and those are the pieces that we will backfill going forward.

20 So I won't go through each data element, but it's a
21 pretty robust data set with some, you know, patient
22 demographic information, the type of contract, the procedure
23 codes and diagnosis codes, dates, service providers,
24 prescribing physician, plan payments, member payment,
25 responsibilities, date paid, and facility type. So it is a

1 robust extract of information that the payers are providing,
2 but it isn't everything we need and we know that. So the
3 excluded -- typically excluded (indiscernible - voice lowered)
4 uninsured. One state is getting denied claims, but why? I
5 just don't get that, but anyway, they don't always listen.
6 Worker's Comp is typically not part of that, at least in the
7 initial building of an APCD. It's just a different type of
8 data set, a different type of payer. We know that referrals
9 are missing, and I mentioned lab work and imaging. We are
10 having some -- you know, the provider affiliation with group
11 practice isn't in there, provider networks, and those in
12 italics are ones that we have some ideas for, and we're
13 working with standards organizations and others to get premium
14 information, capitation fees, administrative fees, and back
15 end settlements because that's going forward important to the
16 states because they want to know what the cost of care is and
17 the cost of trends, and these are big missing pieces. Again,
18 we know that they are not in the claim, but there are ways to
19 back into that, we believe, in the future for states that are
20 farther along in the building of their APCD.

21 So what does it cost in a state to build? It really --
22 we can't give an exact amount of dollars, but it will be
23 driven by what the size of a population in a state is, how
24 many carrier fees and what their thresholds, again as I
25 mentioned earlier. Provider database. Do have an HIE that's

1 building one that you can take advantage of or do you need
2 build your own because the National Provider Identifier is not
3 a clean number? And the state of Maine is spending about
4 \$600,000 just to build their own, and I think they've gotten
5 it, but it's taken them a long time. Some states are hoping
6 to merge efforts with their HIE because some of the Health
7 Information Exchanges are building patient and provider
8 directories. So there could be some cost savings to states
9 building an APCD, if they work together.

10 We are really all over the map in states as far as who
11 gets access to the data and how they release it, but that will
12 even out. That was the way hospital discharge data was 20
13 years ago. I mean, that's just -- this is a new thing, and
14 states are taking a fairly conservative approach because of
15 privacy and confidentiality.

16 And again, we're seeing a proliferation and we will see
17 more of analytics reporting applications and measures. As
18 more states have these big databases, we've already talked to
19 -- well, what we want are some standard Tier I, Tier II, Tier
20 III measures. So the Tier I could be generated off of core
21 data sets, some really basic metrics that states can generate
22 today and that are comparable. Tier III could be ones that,
23 through linkage or enhancement, could be developed down the
24 road to answer more complicated questions.

25 How do states pay for that? Well, however they can.

1 Some of the states have assessments on the providers and
2 payers through legislation that pay for the statewide
3 databases. Most states that have mandates have some sort of
4 general funds, some appropriation from the legislature. We do
5 have states, like Utah, taking Medicaid match, and because
6 it's benchmarked for Medicaid and population health, that is a
7 legitimate use for some of the build of the APCD. We have
8 states, like Colorado, that have private foundation money. I
9 advise against data sales as being a revenue source initially
10 for states because, again, you have to build it before you can
11 sell it and so it's not a very good source for building the
12 database. Some states -- well, most states will have fines
13 for non-compliance, but that isn't a revenue source that we
14 recommend because it's rarely used and it's not a good
15 business model. And then grants. We try to help states and
16 others, you know, look for grants and get some sort of money
17 to help their APCD efforts.

18 Some states see the value in the consolidation of
19 reports, so that payers who are providing the data might not
20 have to report to so many state agencies, the insurance
21 commission, the health department, and everything else. So if
22 you can work out what those data flows are today and get a
23 consolidation plan, there could be some savings. And I know,
24 in some of the larger states, that's a big attractive selling
25 point. And then, you know, I think the Beacon grants are

1 supporting Rhode Island and a couple other states there. So
2 we're out there looking for money.

3 So what are some of the uses? And I cut out a whole
4 bunch, but on the APCD Council site, all the reports that
5 states generate are out there, and there is a huge and growing
6 body of how all payer claims databases are used. But again,
7 the states are designing these for multiple uses, not just a
8 single employer coalition use. They're looking at how health
9 plans can benefit. And if you're a smaller plan in a state,
10 this might be an attractive thing because you can aggregate
11 across all payers and you're not just looking at your single
12 payer experience. For physicians as well, you can look across
13 all the payers and all the experience instead of just a single
14 payer profile. State government can benchmark Medicaid and
15 other populations and look at that, and the federal government
16 is actively recruiting statewide databases for the new multi-
17 claims database that HHS is building.

18 So these are just examples and these are just highlights,
19 and I know the day is long and you may have lots of questions.
20 So I won't go deeply into the charts. I'll just give you sort
21 of the *Reader's Digest* bullet point for some of these
22 applications as a flavor, but I think this out of Vermont is
23 just showing that the database, itself, has inherent value.
24 These are users that have requested the data from the state of
25 Vermont to do these studies. So it isn't the state of Vermont

1 doing these studies, but it's academic organizations and
2 research organizations that are requesting the data to do
3 these kinds of reports that will be submitted back to the
4 state. So I think the database itself has such huge value, if
5 you can have partners in its use because no one state agency,
6 no one state government person can possibly think about all of
7 the questions that could be answered from a database, like
8 this, nor should they.

9 The next slide is more the prevalence -- looking at, you
10 know, Medicaid and commercial populations, for example, and
11 this is just one example by age and by commercial and Medicaid
12 showing the burden of illness in the Medicaid-only population.

13 The next slide is, again, a look at chronic disease,
14 COPD, and the variation, and the rates are standardized by age
15 between Medicaid and commercial in New Hampshire. So this
16 just shows, again, a sort of a regional or a geographic view
17 of chronic illness in a state, looking at both types of
18 payers.

19 This is just prevalence, again, of major disease
20 categories and some trends. So Vermont has had data. I think
21 this is the point that they're starting to get a longitudinal
22 look at health and the health care system and the performance
23 and the cost. And again, the next slide in Vermont is just
24 showing some regional variations of cost and quality by the
25 regions and looking at high cost, high quality, low cost, high

1 quality providers, and starting to get a sense, based on
2 aggregated data, using some composite scores for preventive
3 and effective care. So we are just seeing some modeling and
4 some metrics that are getting a little more sophisticated that
5 can be shared across the states. As one state releases a
6 report, they tend to release the methods, and the other states
7 will adopt some of those practices.

8 So what the meat of it is, I think, is really looking at
9 the components of care and how these episodes come together.
10 A couple of the states have told me that they want more than
11 just global effectiveness measures. They want to be able to
12 be look at the components of care because doctors can't do
13 anything about just a global measure. They want to know -- it
14 may even boil down to what kind of anesthesia was used in a
15 procedure. That effects costs. That informs doctors about
16 how they might improve the care, but a global measure of just
17 a high cost isn't maybe enough. So the more granularity you
18 can get and the more episodes you can define starts, you know,
19 revealing why some of that variation in cost is occurring, and
20 this one is Maine's, but all the states -- every state I've
21 worked with, their goal is to get to episodes of care. They
22 just don't want to know what an arthroscopy is. What goes
23 into an arthroscopy? What are the components of that
24 arthroscopy in between facility care, the whole thing, the
25 whole care, even the prescriptions? Next slide.

1 Again, Medicaid payment benchmarking, but not all states
2 are excited about this, but again, it reveals how plans are
3 pricing and how it compares to Medicaid.

4 States are really interested in per member/per month
5 pricing, and this is just one example of the components of
6 care. I think -- I don't have my glasses on, but these are
7 the various aspects of care by member age, per member/per
8 month rates. And so you can start looking at, you know, the
9 different components, their trend lines, and across the age
10 groups. And again, we can go back to some of these.

11 The next slide out of New Hampshire, I thought this was
12 just -- this was used to plan HIT, and I really like this idea
13 because they looked at inpatient on the left, you know, where
14 patients and where they are getting the care, but they also
15 then were able to take their all payer claims database and map
16 for outpatient services. And where the migrations were the
17 highest, they started with their HIE planning and investments.
18 Instead of covering the whole state, they said, where do we
19 need to talk between regions the most and where should we
20 start? Because, if you start everywhere, you're going to get
21 nowhere. So they picked a few of the high migration areas to
22 start their HIE discussions and implementation, and I thought
23 that just made sense, to me, so I like this graph.

24 Very few states -- all of them have the pharmacy data,
25 but we're just starting to see them use their RX data -- next

1 slide -- their prescription data, and this is just a purchaser
2 group contracted with my University of New Hampshire
3 colleagues to look at generic drug use and pharmacy costs, I
4 mean, proving that generic drugs and per member/per month
5 costs are lower, but starting to drill down into some of that
6 across payers and across the system. Next slide.

7 So Vermont and New Hampshire, and I think, Maine are the
8 ones starting to really look at medical homes and pilots and
9 group practices and per member/per month costs, and New
10 Hampshire is really working hard on physician attribution,
11 looking at global budgets, and evaluating the cost of care
12 across the settings and by practice site.

13 So I think we're going to see quite a few of these
14 applications evolve, but again, the Northeast states are
15 looking at this seriously, and I think Vermont has got some
16 reports out there as well on their medical home, but with
17 these demonstration grants, they have a -- I think the states
18 -- I think the short answer is the states that have the all
19 payer claims databases already implemented are at an advantage
20 to look at care coordination and primary care effectiveness
21 because they have some baselines and they can start
22 benchmarking and seeing where the bang for the buck is and
23 where the savings are, so they've got a leg up.

24 And then we're just starting to have -- the next slide --
25 just enough states putting the same data set together that

1 there are some -- and Alaska probably wouldn't be as
2 interested in this because I don't know that you are a
3 regional -- outside of your own region, but maybe with
4 Washington, but this is a regional look at cross-border, and
5 they use the same encrypted I.D. So they're able to really
6 look across these three states as to what is happening in a
7 tristate area and some of the variation, and this is advanced
8 imaging MRIs and some of the variation in their utilization
9 across the three-state area. Next slide.

10 So again, I will close with a few thoughts, but we are
11 challenged in states with the APCD because, you know, it's not
12 100% of the population captured. It's pretty good, but it's
13 not 100%. We don't see uniformity yet on how states are
14 making it available to secondary users. We're having trouble
15 with the NPI. It's just not a really good number for
16 physician attribution.

17 Again, we have to figure out non-claim payment
18 adjustments and evolving payment methodologies. The states
19 are linking the data to other sources and that's something
20 else; states developing an APCD today probably are at an
21 advantage because the early states made some political deals
22 with not collecting very good identifiers and they can't do
23 very good linkage with their HIEs and their other data sets.
24 States, like Utah and others, that went into this saying we
25 want episodes, we want to link -- have much more robust

1 linkages possible. Again, we struggle with how to pay for all
2 of this and how the Feds have engaged or have not engaged, and
3 those continue to be challenges.

4 Maybe you can skip to just the picture. So again, I
5 always debate whether to use this because this is a lot of
6 information in a slide, but we -- I think it depicts that
7 APCDs are just part of a state data system. They are not the
8 state data system, and they will not be the state data system,
9 but they're a pretty darn good part of it. We still have
10 evolving Health Information Exchanges. We don't know --
11 you've seen HIE; you've seen one HIE. There is no common
12 database, but again, they have potential, and they have some
13 money, and they have some provider directory and patient
14 directory possibilities that could bring some things together.

15 Health Benefit Exchanges. We have two or three states
16 that Health Benefit Exchange is actually working to use the
17 APCD for risk adjustment. So those are ones to watch. So we
18 think that's going to be a very interesting application.

19 We have registries, the public health registries, very
20 good registries, chronic disease and others, cancer
21 registries. So those registries are being linked, in some
22 states, with the APCD to start looking at a more robust
23 clinical picture of what a cancer episode might look like.

24 And then vital records, of course, is always a good
25 linkage database for outcomes and adding additional

1 information, depending on what you're studying. And again,
2 these linkages are not made lightly, and we recommend, you
3 know, a review process and policies in place, but that's
4 getting ahead of where you are now.

5 So I will close with a few lessons learned. Across any
6 data system that's a community or state policy database, I
7 mean, the data supplier -- and I mean providers and payers
8 have to be a big piece of this, and the relationships forged
9 are critical.

10 Transparency -- and more than just transparency in health
11 care. Database transparency. Data system transparency and
12 documentation is essential. What we heard earlier today with
13 the Milliman study, I mean, you use proprietary databases and
14 proprietary tools. You aren't -- I mean, they did a pretty
15 good job, but you have your own database that is well-
16 documented. Everybody understands the limitations. Everybody
17 can replicate the study or the potential to replicate the
18 study. It is critical to the long-term success of a data
19 system.

20 Again, we are big believers in national standards. They
21 aren't the only solutions, but it does -- the payers thank us
22 every time we can get a standardized data rule in a state
23 because, if -- just say you're AETNA and you're in every day
24 and every state writes its own format for reporting, it's 50
25 state abstracts, and it drives them crazy.

1 And then again, linkage opportunities are increasing.
2 Local user, analytical consortiums have really helped in some
3 of these states that look at -- and I think New Hampshire has
4 really got it right. They have the insurance department use
5 the all payer claims database for insurance questions. They
6 have Medicaid using and having a copy of the data from
7 Medicaid-specific policy questions. The health department is
8 using it for population health and chronic disease. So I
9 think they've worked out this triangulation and division of
10 analytic responsibilities that is making some of these
11 applications you just saw roll out of New Hampshire more
12 efficiently than if the state agency is trying to do all of
13 the analysis or one vendor.

14 And again, we believe, if the quality of data and the use
15 of the data improve, the more people that responsibly use the
16 data -- more eyes on the data make better data, and I've seen
17 that over 20 years.

18 So the hard sell is building a statewide reporting
19 program takes a lot of time and effort, but as I think about
20 states I've worked with over the years, if they haven't
21 invested in one, then they don't have one. And each year,
22 they put it off, and you know, kick the can down the road,
23 makes it harder for them to catch up. And this is what I told
24 Mississippi in 2008, either 2007 or 2008, and they now have a
25 functional hospital reporting program with ED data coming in

1 that links to lab data, but just getting them started was a
2 tough sell, but they're fully running today, and I think
3 they'll be looking to expand to outpatient here fairly soon.

4 So I'll close with those thoughts, and I tried to keep it
5 as brief as possible for you.

6 COMMISSIONER BRANCO: Thank you very much. That was
7 really enlightening, and I've got, from the data supplier, a
8 question. Are any states or any programs, have they been
9 successful in automatically filling some of the data? Because
10 I view these -- most of the data supply is manually-based and
11 time-intensive and recurring and very challenging. So what
12 you've got on the top of that slide a few pages ago is "form
13 data supplier relationships," and I presume it's to keep
14 people enthused about continually providing data. Are there
15 any automatic grabber programs or feeder programs that can
16 make some of this data transfer a lot easier, have you seen
17 any?

18 MS. LOVE: On the all payer side, I can't say I have. On
19 the hospital data side where we -- some of the states do have
20 online, pretty good online transfers where they -- I mean, in
21 California where a hospital can report, you know, quite a bit
22 of data, and it's turned around and edited and kicked back in
23 24 hours. I mean, we're seeing some of that automation. Pre-
24 population of sites, I would have to think about that. On the
25 eligibility side probably, because they're the snapshots. You

1 know, the states are getting quarterly or monthly snapshots
2 from the providers of that eligibility information. So it --
3 you know, so it's just updating. So maybe smarter minds than
4 I can I figure out, and as we evolve, there could be smarter
5 extract programs.

6 COMMISSIONER BRANCO: And that could be the benefit of
7 fostering those relationships, working together to find a
8 streaming process to get that data more fluid?

9 MS. LOVE: Right. We'll be meeting in October with X12N
10 to look at the business model for payers. You know, that
11 makes sense to them to -- because, really, what states are
12 getting is a post-adjudicated claims, and claims are built
13 for, you know, transaction. So there may be some thinking
14 there, too, that could -- because the payers want it simpler.
15 They're pushing us hard. They're pushing the states hard to
16 make it simpler, and they should. I just don't have an answer
17 where it's going.

18 COMMISSIONER LAUFER: My understanding is this is sort of
19 data, based on what's billed and what's coded correctly. So
20 there is -- first, there is a big wiggle room, particularly in
21 primary care, between what is done and what is coded because,
22 if I wrote every code down, there would be 12 or 13 on a lot
23 of visits. But this leads to the question, the transition
24 from ICD-9 to 10, is that going to increase your resolution a
25 lot, theoretically?

1 MS. LOVE: It won't increase the number of codes, per se,
2 and there may be some transitional issues, but it'll give us -
3 - I think 40% of the ICD-10 codes, as I understand it, are
4 lateral, you know, I mean laterality. So you're going to get
5 more granular -- and then trimesters. I mean, some of those
6 things will really help our public health.

7 COMMISSIONER LAUFER: Yeah, yeah (affirmative).

8 MS. LOVE: They really will. Doctors are kind of
9 freaking out, you know, because it shouldn't change what you
10 do, but the coding -- the coders will have to be.....

11 COMMISSIONER LAUFER: If we're spending another half-hour
12 every day figuring out numbers, it'll change what we do.

13 MS. LOVE: Yeah, yeah (affirmative).

14 COMMISSIONER LAUFER: But aside from that, I think that's
15 interesting and possibly a very optimistic thing. The other
16 thing is, how we do we, as a country, compare to other
17 countries as far as knowing what we're paying and what we're
18 getting? I mean, (indiscernible - simultaneous speaking).

19 MS. LOVE: Well, because we have so many -- you know,
20 because our system has so many systems, I don't think we know
21 what we're paying for. I mean, it's remarkable that states
22 say we want to know how much we're spending on health care. I
23 mean, we know pieces of it, and you can kind of patch it
24 together. I'm not an expert on other -- I think, with
25 socialized countries or regions, at least in Canada, you know,

1 tell me they can put things together fairly effectively
2 because, you know, they don't have the migration to care. I
3 mean, in certain regions in Canada, they're not going to and
4 from getting care.

5 So from a regional standpoint, I think they have a pretty
6 good snapshot, but from a countrywide, even they have some
7 challenges with the linkages, but -- and just as this is, you
8 know, an aside, I'm going to India next month because they
9 want to know how we do it, and I'm kind of thinking I don't
10 feel very good telling them that we're doing anything right.
11 But again, I think my counterpart out of UNH, Patrick Miller,
12 is also working with the European union, and some things are
13 doing very well, but they're thinking, in other ways, we're
14 putting the data together more effectively, at least in
15 pockets of practice.

16 So I think we're all learning from each other, and all of
17 us are being hit by increasing costs and aging populations and
18 technologies, and there is no magic bullet, you know. So I
19 just work on the dashboard, trying to get states some sort of
20 dashboard that they can then look at because, again, I'm a
21 public health -- in my heart, a public health person, and with
22 all this reform and payment reform, I really want to know who
23 is getting hurt, by how much, what the effect is on the most
24 vulnerable populations because that's the canary in the mind,
25 and I don't -- and with Medicaid reforming and people going on

1 and off, what's happening to those folks in the interim when
2 they're off of Medicaid?

3 So I think states are just putting the jigsaw puzzle
4 together, and it seems pretty crude, but it's better than what
5 we've had.

6 COMMISSIONER ERICKSON: Noah, and then Wes and Keith when
7 you're done.

8 COMMISSIONER LAUFER: My guess is we won't see the full
9 impact of these kind of databases until they've been up for
10 decades. You know, one of these favorite things is, you know,
11 10% of the population costs 60% in a given year. Well, how
12 many of us will be one of those 10% at some point in our life?
13 And then it starts to put us all in the same boat together.
14 And a lot of, you know, the study for two years or whatever,
15 it doesn't -- it never is going to pick up the really
16 meaningful care.

17 MS. LOVE: I'm a little more optimistic. I think it will
18 be not decades because I'm seeing the states -- even, like,
19 Utah that's not 100% complete -- the value of these databases
20 evolve, and again, the more complete and the more years you
21 have the better your forecast and the better you are able to
22 look at, but in my experience in Utah, it took about two or
23 three years and use of the data, dissemination of the data,
24 but what it did is it alerted us to -- because I was telling
25 someone else a story. Utah always looks good, I mean, in a

1 lot of metrics. So one of the arguments was we don't need to
2 invest in any databases because we -- and we're always
3 (indiscernible - voice lowered) Nevada, and we just, you know
4 -- but what really was astounding when we put it together was
5 the huge variation within Utah. That got attention. When
6 rural hospital C-section rates were four-fold higher than the
7 tertiary hospitals, people didn't believe it. We had to --
8 and that's where a community database -- because they thought,
9 oh, it's the state, you know, screwing up. So that data was
10 provided to third parties. We looked at it. We had a task
11 force. It really turned out to be, which hospitals had an
12 anesthesiologist on staff for C-sections because, if you're
13 calling out an anesthesiologist in rural Utah in the middle of
14 winter on an icy road -- that's what the hospital -- you're
15 committed. I mean, you don't make that call unless -- in a
16 big hospital, you can send the intern down the hall to sleep,
17 you know, a couple more hours, and you can kind of -- so those
18 are the kinds of things that prompted telehealth partnerships.

19 So the data does have inherent value, if nothing else,
20 just to say I don't believe it or there is something going,
21 but we can't explain it. And so that's where, I think, the
22 data is so powerful because they get people either engaged or
23 they want people to understand what's going on. It may be an
24 artifact of the data, but it gets people talking about it, and
25 I think it's great.

1 COMMISSIONER KELLER: Thank you. I've been on the data
2 quality -- what is the name of that? But they got kind of
3 bogged down in the confidentiality stuff. But I was
4 wondering, from your perspective, if we were to do this in
5 Alaska, does it have to be -- pretty much, is it a given that
6 it has to be top-down, mandate-driven? You mentioned
7 identifying stakeholders and getting buy-in, but how do you
8 get there from here? You know, I mean, we have thousands of
9 databases in the state of Alaska, just in the public sector,
10 you know, that don't even -- you know, I mean, there is no --
11 they've completely been evolved, you know, and they don't talk
12 to each other. So we have nobody -- we have no central --
13 again for the public perspective, we have no central authority
14 to set standards for how things are done. So I don't see how
15 we can get at this, except through a mandate top-down, but you
16 indicated no.

17 MS. LOVE: One of NAHDO's jobs is to work with the state,
18 and the state environments are different and the state laws
19 are different in authorities. So part of that work has to be,
20 what is possible in a state? Because what's possible, you
21 know, say in Utah is not going to work in Colorado, even
22 though we're right next to each other. And so they have a
23 pretty good voluntary hospital reporting system for -- that
24 the hospital system maintains, and everyone is happy with it.
25 So it's really -- I don't think it can be dictated and that's

1 why I always get scared of the federal solution because,
2 again, the stakeholders on the ground, it's what they're
3 willing to do.

4 Now in Utah, I thought voluntary was going to be the way
5 to do the all payer claims and some of these newer data sets
6 as a demo, but some of our major hospital folks and plans were
7 saying, if the state thinks it's important enough to collect,
8 have them write a rule and make all players play by the same
9 rules, and you know, be transparent. But in some states --
10 Hawaii just can't get to legislation, and they have some
11 pretty good data systems. It just -- I'm a fan of a mandate
12 because it kind of forces everyone to say here is what we
13 want, and here is how we're going to do it, and here are, you
14 know, the ground rules.

15 COMMISSIONER KELLER: (Indiscernible - away from mic)
16 Two quick follow-ups. First of all, what -- who would -- just
17 real quickly, who would oppose? I mean, who do you find is
18 the biggest opposition to the development of these databases?

19 MS. LOVE: Usually perhaps, the data suppliers because
20 they're worried about the burden. The second group that we
21 just have to engage with are privacy folks, the consumers, the
22 public because it's -- rightfully, it is information about
23 individuals that is rolled up. And so the public has to know
24 the public good of this, that it's not some secret, you know,
25 state database that's going to be used. It's a statistical

1 abstract. All -- I mean, so we're in conversations across
2 states all over to try and help them couch -- and in some
3 states, they've had some pretty weird -- like Minnesota, to
4 get their all payer claims database, they had to promise that
5 nobody would ever use it, only the state, which -- and -- but
6 we supported that because that was the only way to get it in,
7 and guess what, just what I predicted. Already, the people
8 are on the door saying -- the universities and others saying
9 we need to open it up a little more and that's perfectly
10 natural. You just do --- because my philosophy is no data is
11 more harmful to the public than even some data, if it's done
12 properly, and that some data leads to more, you know, data as
13 more people are engaged. So you -- and this is why I don't
14 want to come to Alaska and say, if you do this, this will, you
15 know, work. We think we have a pretty good roadmap, but you
16 would have to ferret out some of the issues and find out who
17 the opposition is and what they can live with because, I
18 think, everyone wants information now. I think it's clear
19 that transparency is going to happen. So it's just that how
20 it will happen here might play out a little differently than
21 it did in Utah.

22 COMMISSIONER KELLER: That's the perfect lead-in to my
23 last real quick question. Assuming we precipitate legislation
24 possibly, would you -- do you go and like, testify and help in
25 the process of the legislation passing?

1 MS. LOVE: Yes. Yes. And we -- or write or -- and
2 again, this group that we put together through UNH, we do
3 webinars for key stakeholders. We're on the ground in
4 Delaware, Ohio, New York. We've been quite active in New
5 York, and I think New York will have their data regs defined
6 pretty soon. So we do engage in legislators, too.

7 COMMISSIONER CAMPBELL: I'm going to ask the most
8 dangerous question all afternoon. Do you have an average cost
9 per person or per abstract that this might cost us or whoever
10 is doing it?

11 MS. LOVE: No, because it even varies by plan, you know,
12 and their platforms and what kind of system they have. We
13 guess that it's, depending on the size of the state and the
14 number of feeds, a half-a-million to a million a year to put
15 it together, which isn't huge, but it is -- that's what it
16 costs to aggregate. The wild card is how much analytic
17 because, if you have vendor doing analytics, that could, you
18 know, triple your amount. If you do partnerships with
19 analytics, you know, that could reduce it. The real cost --
20 and we do have a cost sheet that we wrote, and it may or may
21 not be in your packets, but it's on the APCD Council site, but
22 I can make that available, and we go through some of the cost
23 considerations for that. But you know, it depends what agency
24 is running it. If it's a private agency or a state agency but
25 they already have hospital or other reporting systems, they

1 may have that infrastructure, so more than anything, it takes
2 programmer and server space. If you go with a vendor, there
3 are vendors that, you know, are multiple states, and it may
4 just be marginal costs. So you know, these are things that
5 just don't have a hard and fast answer, and if I had it, I'd
6 give it, but I'm afraid that I'd be wrong no matter what I
7 said.

8 COMMISSIONER ERICKSON: Other questions or comments for
9 Denise?

10 MS. LOVE: One more thing is another thing the state
11 needs to do is kind of look across, you know, authorities
12 because there may be shared authorities. There may be an
13 insurance component where they have authority to compel
14 certain things. There may be a public health authority, and
15 Maine is using public health authority, you know. So
16 analyzing where those authorities may already exist or where,
17 you know, legislation may bring those together and then it
18 could also be a shared cost because -- and again, it could
19 consolidate other reporting streams that are coming into the
20 insurance department or the state. Then once the data set is
21 built, public health is very eager to have this as database,
22 so that's another revenue potential as they write grants or
23 write for programs, that they can build that in, and it makes
24 them more competitive for whatever they're seeking. So again,
25 we try to help that assessment on the ground in the states.

1 CHAIR HURLBURT: Any other questions or comments? Thank
2 you very much. Thanks for coming up here from Utah and your
3 presentation. And I think we would be interested in -- we're
4 a little ahead of schedule now. I think we're probably wired
5 into a fairly harsh start at 3:30 with the next session, but I
6 wonder, Paul and Jeannie, would you folks be ready to step in
7 now because, I think, we've got a half-hour, if you all could
8 do it now? Would that work?

9 COMMISSIONER ERICKSON: Is that okay? We were scheduled
10 for 4:30. Paul Cartland, the State Health Information
11 Technology Coordinator -- and since we're kind of on a data
12 theme right now, too -- was going to just give us a quick
13 update on the status of Health Information Exchange
14 implementation, and Jeannie Monk from the Alaska Hospital and
15 Nursing Home Association is going to update us on the status
16 of the hospital discharge database, so we'll move ahead to
17 that. And we have a PowerPoint presentation. There is a copy
18 on the website for folks who are on the phone, Paul Cartland's
19 presentation, and we also have hard copies on the back table
20 for folks in the room and in Commissioners' handout packets.

21 MR. CARTLAND: How's that? I talk loud, too. If you
22 would go ahead and go to the second slide?

23 Just a quick update on where we are with the Electronic
24 Health Record incentives. This slide is out-of-date. As of
25 this morning, we had authorization to make seven additional

1 payments. So that \$658,750 will go up by another almost
2 \$150,000 in the very near future. We've had -- Alaska
3 Regional has submitted their attestation, so we're working
4 through all that validation, and we'll, hopefully, be making a
5 payment to Alaska Regional in the near future, and then
6 Central Peninsula Hospital is in the process of gathering
7 their attestation validation information, and we will,
8 hopefully, be paying them before too long as well. The next
9 slide.

10 And by the way, because of a number of things, one of
11 them being the regional extension center efforts that have
12 really picked up recently, we're starting to see a real influx
13 of folks registering for those incentives. I think we've had
14 almost ten, this week, additional providers, you know, a
15 couple a day, which is good news.

16 On the Health Information Exchange, there are three pilot
17 sites that are transferring data. The data -- or the three
18 sites are listed on the screen there. We began user
19 acceptance testing yesterday with those three sites. They're
20 testing some of the functionality, you know, the ability to
21 log into the clinical portal or the ability to change their
22 passwords, and you know, the normal administrative type
23 functions, but also the ability to search for a patient and
24 view demographics, allergies, and alerts, and counter history,
25 appointment history, medication history, you know, problem

1 lists, procedures, continuity of care documents, lab results,
2 radiology reports, both within the Health Information Exchange
3 clinical portal, but also looking at some of that same
4 information from within their own electronic health records.

5 We are hoping that we'll begin production implementation
6 towards the end of September and then we're off to the races.
7 The next slide, please.

8 One of the things that we'll be rolling out in late
9 September is something called the National Health Information
10 Network Direct Project. It's a secure messaging solution. It
11 takes a while to onboard a facility onto the Health
12 Information Exchange. You don't just connect up and you're
13 there. It takes a while to interface, test, and all of those
14 things. So it will take a while to get all of the providers
15 that want to connect connected. And we need to have a method
16 to facilitate allowing those providers to meet meaningful use.
17 That's required for their electronic health record incentives.

18 What the NHIN Direct Project does is it's a secure push
19 messaging solution, so it allows a provider who has a NHIN
20 direct email address to send a continuity of care document or
21 referral, a lab result, a whatever health information in a
22 secure manner to another known provider who has a direct email
23 address.

24 The Health Information Exchange is going to implement
25 that from within the clinical portal. So a provider could log

1 in, access the direct functionality, compose the email
2 message, attach whatever document from their electronic health
3 record, and then send it to whoever that provider is. Next
4 slide, please.

5 The State and the Department are working with a vendor, a
6 contractor to help us define what our architecture will be for
7 connecting all of the State's disparate databases that we were
8 referring to, or I heard referred to, earlier to the Health
9 Information Exchange where appropriate. So we're defining the
10 State's data needs. We're determining what the system
11 architecture looks like for connecting EHRs in a provider's
12 office through the Health Information Exchange to the
13 immunization registry, rather than having each provider have
14 to connect individually to the immunization registry. We're
15 doing the same with the State's laboratory information
16 management system, and we'll bring those individual
17 connections on in a logical order, but we're focusing first on
18 lab results, immunization, and then the ability to share
19 continuity of care documents and those kinds of things.

20 The Department and the Alaska eHealth Network, along with
21 a number of folks from out in the community are working on
22 various workgroups to look at privacy and security around the
23 Health Information Exchange. There is a clinical workgroup
24 looking at how to make the Health Information Exchange be a
25 value add for a provider, a technical workgroup looking at the

1 architecture and making sure that we're doing the right thing.

2 COMMISSIONER CAMPBELL: I have a question. You mentioned
3 immunizations here, and I can see how it would work on state -
4 - because you've got the public health versus -- you've got
5 clinics who are going to do this, but I just heard Ward, this
6 morning, stopped off at Safeway and got his flu shot. How
7 does he get into the system, so that all this is counted? I
8 assume every Safeway store is not going to be part of the
9 Health Information Network.

10 MR. CARTLAND: Well, ideally, that probably happened at
11 the Safeway pharmacy, and the pharmacy will connect to the
12 Health Information Exchange, and the fact that the pharmacy
13 gave that, you know, they're billing somebody for it, and
14 hopefully, they're adding that into the Health Information
15 Exchange, so that it would automatically feed to our
16 immunization registry to help give us better data.

17 COMMISSIONER LAUFER: They do, actually. If you get a
18 flu shot at Fred Meyer's, I get a fax, usually. But what
19 tends to happen with this kind of information when it's free
20 for them to share it is they say hey, here is some information
21 about your patient. You're on the hook. You're not going to
22 get paid, but your liable. Thanks. And this is one of the
23 dangers of this, is all the information flows to us. Somebody
24 gets their labs somewhere else and then no one there knows the
25 significance of it, but it just bounces to me, and I don't

1 know labs were done until there is a notice on my desk on
2 Monday that says critical lab on one of your patients. Don't
3 know where they are, haven't seen them for a year. I'm
4 liable. They profited from doing the lab and charged
5 somebody, and this is one more example that the primary care
6 doc just gets -- you know -- and this happens a lot. Saw your
7 patient today for this or that. I'm concerned that they might
8 have heart disease. You should follow-up with them. You
9 know, it's a dumping of information and not a useful exchange
10 of information. So you can see why I might just say I'm going
11 to go back to paper charts. I don't need an incentive.

12 CHAIR HURLBURT: But don't you think that's the way the
13 system works now? If you go into Fred Meyer's or into
14 Safeway, who is your primary care physician? They want to
15 know the phone number, which you won't have a clue, but they
16 dump it on you that way. If we have the system Paul is
17 talking about and the billing that goes to Medicare or Alaska
18 Care or whatever, then it's in the system, so that, when you
19 see the patient, you know my patient needs a flu shot. My
20 patient needs a Pneumovax or something and that pops up for
21 you. It's there. So you're not getting dumped on, but it's
22 more of a resource to you.

23 COMMISSIONER LAUFER: It has to be more of a resource for
24 us to play, but already, the electronic prescribing, the
25 pharmacies generate requests for refills, and I call the

1 patient and they have no idea what I'm talking about. I never
2 asked, you know. That's a business pump, and I don't --
3 that's somewhat unethical. Your patient needs to get a flu
4 shot and didn't and they get the flu and die; am I liable?
5 You know, this will happen for sure in a system, like this.
6 If you can externalize your risk to somebody else, they will,
7 especially if you can do it for free.

8 MR. CARTLAND: I've gone through my slides. If you have
9 other questions, I'm.....

10 COMMISSIONER LAUFER: I don't mean to bristle, but that's
11 what's going to happen, and these are, you know, resistances
12 that you're going to see that might not be anticipated, you
13 know. On a busy day, what do I do with this data that's
14 coming in, these emails that come in that come from nowhere or
15 are not generated by a patient?

16 MR. CARTLAND: I understand your concerns.

17 COMMISSIONER ERICKSON: Thanks for the update. Jeannie,
18 you can come on up right now. Just as a reminder, I wanted to
19 point out, too, in your notebooks, I believe in the back of
20 tab two -- in an earlier meeting last winter when we were
21 talking about the importance of the Health Information
22 infrastructure for being able to make sure we have adequate
23 data for applying and using information for making better
24 decisions for health and health care, a hospital discharge
25 database came up, just as an example of an area where there

1 might be some gaps in data because of incomplete participation
2 by the hospitals in the system right now, and the group kind
3 of took off with that and wanted more information about it,
4 and department leadership then had more questions about it.
5 And so we've drafted a white paper to provide some current
6 information, and Jeannie and ASHNHA have been feeding
7 information into that, and Jeannie has come to update us on
8 what ASHNHA's role and the status of the additional work
9 around the hospital discharge databases. Thanks.

10 MS. MONK: Hi, I'm Jeannie Monk, and I'm with the Alaska
11 Association of Hospital and Nursing Homes, and I feel lucky to
12 be going after Denise. I think I'm going back to Data 101,
13 and it's something we can -- it's much easier to get a handle
14 on than the all payer claims.

15 So just a little bit of overview. Deb did a great job
16 putting together a white paper on hospital discharge database,
17 and I'll cover some information in that and then share a
18 little bit about what ASHNHA is doing.

19 Hospital discharge data has been reported since 2001, and
20 ASHNHA contracts with the Hospital Industry Data Institute,
21 which is part of the Missouri Hospital Association, to collect
22 and analyze the data from Alaska hospitals.

23 Hospitals are requested to submit inpatient and
24 outpatient data on a quarterly or annual basis to HEIDI, the
25 Missouri data warehouse, and then this data is summarized and

1 annualized on an annual basis. Each hospital receives a CD
2 with their own hospital data on it and a set of reports that
3 compares their individual hospital with the other reporting
4 hospitals. ASHNHA also receives reports for the whole state
5 and then the State Department of Health and Social Services
6 receives the data file that allows analysis of the data. So
7 the data is kind of distributed in three different ways.

8 The reports contain comprehensive information about
9 hospital utilization patterns, patient characteristics. The
10 discharge data is sorted and displayed in a lot of different
11 way by service area, by DRG, by county or borough, zip code,
12 age, payer category. So there is a lot of information.

13 ASHNHA receives a grant from the State DHHS to support
14 the contract with HEIDI to pay for the collection, analysis,
15 and distribution of the data. The grant we receive, really,
16 is just enough to cover the contractual costs and isn't enough
17 for us to really analyze and do much with the data. It's
18 \$87,000 a year, and most of that goes to HEIDI to pay for that
19 contract.

20 In 2010, 11 hospitals reported inpatient data, and
21 although 11 doesn't sound like very many out of 27, it does
22 represent 75% of the discharges. So the big hospitals are all
23 reporting. Nine hospitals reported outpatient and ER data,
24 and this represents about 40% of the hospital outpatient
25 discharges. And I think it's really important to note that

1 only hospitals are asked to report their data. So the
2 outpatient care provided by hospitals is being reported, but
3 ambulatory surgery centers, imaging centers, outpatient
4 clinics, like community health centers, private practices, are
5 not reporting any outpatient data. So it's 40% of hospital
6 outpatient services, not 40% of all outpatient services.

7 So one of the challenges is incomplete data and that
8 there is only a portion of the hospitals participating in the
9 system, and we've spent a lot of time looking at who is
10 reporting, who is not, and why aren't they reporting.

11 Currently, the majority of the large hospitals are reporting.
12 MatSu is the only large hospital that's not reporting
13 currently. Elmendorf has not been reporting, but they are in
14 the process of restarting. So that's in the works and a data
15 agreement should be signed very soon.

16 So the non-reporting hospitals are primarily the small
17 critical access hospitals, primarily the independent ones.
18 The tribal regional hospitals are not reporting; however,
19 Alaska Native Medical Center. So we do capture the bulk of
20 the inpatient admissions. The military hospitals are not
21 reporting, although that will change with Elmendorf, and
22 mental health hospitals are not reporting.

23 So I think Deb's white paper really outlines some of the
24 challenges and why there is incomplete data, and I think that
25 there are a variety of reasons. For the tribal facilities,

1 many of those facilities have converted from Indian Health
2 Center status. They haven't, historically, had a history for
3 billing services. RPMS is not well-suited for doing this kind
4 of reporting. They also have many federal reporting
5 requirements through IHS. So the voluntary is an excessive
6 burden, and they haven't engaged in that reporting. The small
7 rural critical access hospitals often do not have the
8 capacity, the staff capacity, or the electronic systems to
9 make it easy to report. There are also obstacles regarding
10 HIPAA and patient privacy and those, in terms of reporting.
11 Although, I think those are really part of the past, and I
12 think people can move beyond that now.

13 One other big challenge for the smaller facilities is not
14 seeing a value in the data. So it's not data that they feel
15 like they need and so reporting it so other people have it,
16 they haven't been convinced of the value. And that's also
17 related to kind of a general underutilization of the data,
18 which there are many reasons. I think the comment that Denise
19 said of everybody wants it, but nobody wants to pay for it is
20 probably the biggest challenge. And I know the Department
21 works very hard every year to piece together this little grant
22 that comes to ASHNHA to support it, and it ends up being,
23 like, ten different people are paying a little piece of this
24 \$87,000. So really, people may be willing to pay a little
25 bit, but there has really been a lack of stable financial

1 support for collecting and analyzing and making good use of
2 the data, and I think that is reflected in the participation.

3 And in general, you know, ASHNHA faces those same
4 obstacles. We don't have a data person. I'm as close as we
5 come to it, and I never signed on to be the data person. So
6 I've been, you know, kind of trying to feel my way through and
7 make sense of it all. Thanks.

8 So really to do the analysis and interpretation of the
9 data, both at the state department level and at the hospital
10 level and at the ASHNHA level, it really requires dedicated
11 staff capacity and training on how to make good use of this.

12 So we've talked about solutions and what do we do to
13 increase participation, and in the white paper, there are some
14 different options outlined, one of which is mandatory
15 reporting, and we feel pretty strongly that we have not really
16 made good use of what needs to happen for voluntary reporting
17 to be successful and that mandatory reporting wouldn't
18 necessarily solve the problems. When we look at who isn't
19 reporting, a mandatory reporting requirement might exempt
20 tribal hospitals. That's a likely scenario. It also might
21 exempt critical access of very small hospitals or military or
22 behavioral health. And so the ones who are not reporting are
23 the ones who would probably advocate for an exemption. And we
24 really think that voluntary reporting could work, if there is
25 more leadership and more active solicitation of participation.

1 And to do that, it will take more resources devoted to
2 collecting and really -- for the small hospitals, really
3 sending somebody out to the facility and helping the facility
4 set up what's necessary to transmit the data. It's not
5 difficult, and for most of the small hospitals, they have an
6 electronic data system, and it's possible for them to set up
7 their billing system to electronically transmit a report once
8 a quarter, but it takes some set up, and they might have to
9 purchase additional software for their electronic health
10 record or billing system. They might need to train a staff
11 person. Something has to happen. And so we haven't done that
12 detailed analysis of really looking individually at each
13 facility and what are their obstacles.

14 For the tribal facilities, it's really a leadership issue
15 of deciding, do we want the tribal facilities to participate
16 and then what needs to happen to get the regional hospitals to
17 participate, and again, to address each individual facility's
18 obstacles to collecting the data?

19 So I think the things that we need to do -- people know
20 what needs to be done. There just isn't anybody with the time
21 and the capacity and the experience to really devote the time
22 that it would take is kind of my summary, and I am working
23 through it kind of one facility at a time, but it's one very
24 small piece of job responsibilities. And so you know, it's
25 limited.

1 Yesterday, I actually got a call from one of the small
2 hospitals wanting some data, and it's data that would be
3 available, if they were reporting. And I told them that I can
4 go in, and I can look at the reports, and I can see this
5 information they're requesting, but the policy is, if a
6 hospital doesn't report, they don't get. So I was able to
7 tell them, you know, if we could find a way for you to report,
8 then you would be able to have access to the data, and they're
9 interested in where are patients from their community going,
10 if they're not coming to their hospital and that's information
11 that's useful to some facilities.

12 So I think with some education, we could get more
13 reporting. I don't think that mandatory reporting will
14 necessarily be a quick fix either. I think there is some hard
15 work necessary, but it sure is a lot easier than creating an
16 all payer claims database. So when I heard what's involved in
17 that, I thought we've got it easy on the hospital discharge
18 database. So that's a quick summary. Are there questions?

19 COMMISSIONER ERICKSON: Val?

20 COMMISSIONER DAVIDSON: The other issue is not
21 necessarily related to this, but certainly has implications.
22 Sharing data is certainly a two-way street. I know our
23 epicenter, which is the epidemiology center for the -- the
24 epicenter for the whole state for all of this whole entire IHS
25 area has been unsuccessful in getting the State to release us

1 information that we rely upon for a number of grants and for
2 representing the health status of Alaska Native and American
3 Indians who live in this IHS area. And so -- and ironically,
4 that same information that comes from our epicenter is
5 information that everyone uses to be able to apply for these
6 grants, federal grants, a number of other grants to be able to
7 say that these are the health disparities among Alaska
8 Natives, these are the leading causes of death, leading causes
9 of hospitalization, et cetera. And unfortunately for us, we
10 have been unable to convince the State that we really need a
11 better data sharing agreement, so that we can actually get
12 more accurate information because it simply hasn't been a
13 priority for them, for whatever reason. I mean, everybody is
14 completely overwhelmed with a whole host of things, and we've
15 been trying to get that agreement now for the last two years.
16 And ironically, the information that the State is now going to
17 be relying upon is about to be really inaccurate data, simply
18 because we can't get accurate data from the State. So it's
19 the cyclical problem of you show me yours and I'll show you
20 mine, and at some point, it just becomes past the point of
21 ridiculous, and you know, it's gone on too long, and we've
22 basically given up that we're going to be able to get that
23 information anymore and have it be reliable.

24 So unfortunately when people submit grants and they cite
25 our data, we're going to start having to send out disclosures

1 that say, by the way, this information isn't necessarily
2 independently variable anymore because we're not convinced
3 that the data is accurate. So the whole data challenge --
4 it's not your issue, but the whole data challenge goes both
5 ways. It has to be a priority for everyone, not just for the
6 hospitals, but for the State with whom we have agreements to
7 be able to provide accurate information.

8 MS. MONK: I think your point about the data agreements
9 is right on. What we found is there is a need to update data
10 agreements at all levels, that we have very old agreements,
11 and there is a new sophistication related to data and privacy
12 and sharing and that is part of it and that contributes. You
13 know, we have data agreements with our hospitals that are old
14 and hamper things, and the same thing with the State. So yeah
15 (affirmative), it is getting everybody to kind of agree on how
16 we're going to share.

17 COMMISSIONER DAVIDSON: Well, ironically, ours were the
18 new negotiated agreements that they said couldn't be --
19 anyway, for whatever reason, we have big challenges in terms
20 of sharing data with each other. And so the problem is more
21 than just hospitals not being able to share the data. It's
22 everybody sharing the data. So I would just urge your
23 consideration of those other factors.

24 COMMISSIONER KELLER: If I could, twice, I've run a bill
25 that has given me some insight into why the data might not be

1 available. It is not so much that there's a protection of the
2 data; it's that there is no standards and it's not as easy as
3 you think. It's a -- there is no -- it's not as easy as you
4 think in the sense that one -- I'm going to call them silos.
5 I don't mean to be pejorative, but one silo doesn't know what
6 the other silo is doing. And so this goes across grain with
7 my fundamental philosophies of government, but that is one
8 infrastructure that has evolved in the Department of Admin.
9 Maybe that's what we need to do is to have a place where the
10 buck stops, you know, as far as setting standards and setting
11 the data agreements. I was appalled to see that there is
12 nothing there, I mean, nothing that you could get your hands
13 on anyway.

14 COMMISSIONER ERICKSON: Val, can I just check in? Is
15 that specific to Vital Statistics data, which I know has been
16 an issue for way more than two years? It is specific to Vital
17 Statistics; okay.

18 There are specific state laws that are, at least, being
19 interpreted as being very restrictive on sharing that
20 information, but I wanted to clarify, just because, as I work
21 over the next few months on a Health Information
22 infrastructure description for our 2011 report and making sure
23 -- this is an issue that comes up at every meeting as the
24 frustration around two-way generally of data -- that I'm
25 understanding the issues as they come up.

1 COMMISSIONER DAVIDSON: And if I can clarify, the state
2 law has not changed?

3 COMMISSIONER ERICKSON: It has not, and that is correct.

4 COMMISSIONER DAVIDSON: It has not changed.

5 COMMISSIONER ERICKSON: Jeff?

6 COMMISSIONER DAVIS: Yeah (affirmative). Thanks,
7 Jeannie. I have a question for you. So it sounds like this
8 hospital database, (indiscernible - voice lowered) database is
9 a bit of an orphan, and really, I mean, you described the need
10 for someone to really take it on. Do you have any thoughts as
11 to who might want to adopt this thing or who would be a good
12 adoptive parent to raise it?

13 MS. MONK: I don't know that it necessarily needs a new
14 parent, but I think maybe the adoptive parents need some
15 resources or some support. It's kind of like you pick a high-
16 needs kid and you adopt it out without giving them the support
17 they need to be successful. So I think the Department needs
18 more resources to devote to analysis of data. I think ASHNSHA
19 needs more resources to devote to helping the hospitals, and
20 some of the small hospitals, frankly, may just need some
21 resources. They may need \$5,000 or \$10,000 to purchase the
22 software patch that's necessary or send somebody out for
23 training or do whatever it takes, and from the small
24 hospital's perspective, you know, some of these hospitals have
25 an average daily census of one or two. So they look at a

1 hospital database and they think, how are my, you know, 150
2 discharges going to impact one way or the other? And it
3 doesn't seem that critical to them to get their data in there.
4 So if, as a state, we say it's very important to have all of
5 these hospitals, then I think they need some more support to
6 make it happen, and hopefully, you could set something up so
7 that, you know, I think it would be possible to help them with
8 some one-time resources, not on an ongoing basis. But again,
9 it means really doing some background resource on each
10 individual situation.

11 COMMISSIONER ERICKSON: Dave, did you have a question or
12 a comment?

13 COMMISSIONER MORGAN: No.

14 COMMISSIONER ERICKSON: I thought I saw your hand up.
15 Denise has something to add.

16 MS. LOVE: (Indiscernible - away from mic)

17 COMMISSIONER ERICKSON: Can you come to the mic with
18 Jeannie?

19 MS. LOVE: I don't know where you are with the Health
20 Care Cost Utilization Project, but I read that that might be
21 of interest to (indiscernible - voice lowered). And I'll say
22 offline or.....

23 COMMISSIONER ERICKSON: Why don't you go ahead and have a
24 seat? We have a couple more minutes before our break.

25 MS. LOVE: Well, I don't want to say -- there may be some

1 revenue opportunities in that, without saying too much. I
2 don't want to, you know, put it on the record.

3 MS. MONK: Well, I meant to give an update. The ASHNHA
4 board did approve in June participation in HCCUP, which is the
5 Health Care Cost and Utilization Project. We are in the
6 process of working on a data agreement, another agreement, to
7 share the Alaska data. We've become a partner with HCCUP and
8 so we share the hospital discharge data with HCCUP, and they
9 use it to populate a couple of national databases. And we do
10 -- you know, there is an opportunity to get some resources.
11 It's not a lot. It would be in the, you know, \$10,000 range.
12 And maybe -- we'll talk about what we -- because our database
13 isn't complete, we can't get top dollar for it right now, but
14 that, hopefully as it becomes more complete, it could
15 generate. So that's one little piece of revenue, but HCCUP
16 has been very interested in having Alaska data because we have
17 unique populations and situations. And so we will, very soon,
18 be a partner with HCCUP and that will bring it up to 45 states
19 participating in HCCUP. And we won't be reporting the
20 ambulatory surgery because that's not data that's being
21 reported by the hospitals, but we will be reporting to the
22 other two HCCUP databases.

23 COMMISSIONER ERICKSON: That is good news. I know the
24 Public Health folks are going to be happy about that, at
25 least. Just I wanted to remind folks, too, as we've had our

1 conversations about Health Information infrastructure, if you
2 remember our funnels, we picked up specifically on the fact
3 that there were hospitals that aren't participating and so
4 that was creating a data gap in this particular database, but
5 remembering the other funnel -- bubbles that are in the funnel
6 that are important parts of that infrastructure that Jeannie
7 referred to as having the capacity to do the analytics and
8 actually do something with the data, and I think it actually
9 is -- this database has been an orphan on the Department side
10 with not really having a strong home and leadership, and I
11 hesitate to say that because I don't want to suggest that
12 that's anybody's fault. It's not to blame, and it's not
13 anybody's fault at all. There just hasn't been a core
14 resource available for supporting the analysis and use of that
15 data, and we have a couple of programs that have good analysts
16 who have been able to pull the data and use it for some
17 specific public health purposes, but it's just something we
18 need to be aware of. The only problem is not just with a few
19 hospitals not reporting. Jeff?

20 COMMISSIONER DAVIS: A follow-up question. I noted in
21 the white paper that the data is only available to DHSS and to
22 the ASHNHA hospitals who are participating. Any discussion of
23 making it available more broadly? I mean, I think, if other
24 potential users were buying it and using it and finding
25 utility, that it then be a synergistic effect.

1 MS. MONK: I think that's a great idea, and I understand
2 some states do have a public database available where you de-
3 identify and remove certain things, so then it's a searchable
4 database and that's certainly something, you know, as we look
5 at redoing data agreements with the hospitals, that we could
6 look at because I think the more value people see in the data
7 the more likely they are to submit it and have it be accurate.
8 So I think that's a good idea.

9 Right now, the data -- you know, people can access --
10 well, through a couple of the state employees who have access
11 to the data set, they do do special reports on request, but
12 their time is limited. So it is a matter of knowing who to
13 call and getting them on the right day, when they'll actually
14 do the reports for you.

15 COMMISSIONER ERICKSON: Any final questions or comments
16 before we break?

17 CHAIR HURLBURT: We'll break and be back at 3:30.

18 3:18:13

19 (Off record)

20 (On record)

21 3:32:31

22 CHAIR HURLBURT: If we can go ahead and get back
23 together, I think we have another very interesting and
24 stimulating session coming up here. We have Commissioners
25 Hultberg and Streur here from Department of Administration and

1 Health and Social Services. We want talk a little bit, where
2 we've talked many times, the State is a very big player in
3 health care and purchasing health care in the state with state
4 employees, retirees, Medicaid, the other things that we've
5 mentioned, corrections, Workman's Comp. And so since
6 Commissioner Hultberg has been appointed, I know she and
7 Commissioner Streur have been talking a lot and working
8 together closely, and Commissioner Hultberg has been looking
9 at what the State has been doing and has a presentation. I
10 understand you will be making the presentation for us, and
11 Commissioner Streur will be doing some reacting and telling us
12 some stories from his extensive background. So we welcome you
13 and appreciate your being here, and if you could go ahead,
14 please?

15 COMMISSIONER HULTBERG: Thank you, and thank you for
16 having me here. I thank you for the work that you are doing
17 in exploring some really important, but sometimes difficult,
18 topics, but topics that are very relevant, not just to the
19 industry, not just to patients or on the state, but really to
20 the entire state of Alaska. So thank you for that.

21 Some of the slides I'm going to present to you I want
22 kind of give you an idea of where they came from and why we
23 were looking at this.

24 In the Department of Administration, we oversee the
25 Alaska Care Plan for our active state employees and PERS and

1 TRS retirees, and there will be some statistics a little bit
2 later in the presentation on the membership of those plans.
3 But we began to take a look at the health care costs that
4 we're seeing and then thought well, you know, maybe someone
5 else is doing it better and maybe Medicaid is seeing a
6 different rate of growth. Maybe Corrections is seeing a
7 different rate of growth. So we aggregated a lot of that
8 information together and came up with some of the information
9 in this presentation.

10 So I'm going to just walk through this, and Commissioner
11 Streur, I think, is going to add to it from his experience and
12 then we'll be available for questions.

13 So first of all, I'm just going to spend a little, a very
14 short amount of time just talking about the big picture. I
15 know you all deal with a lot of very detailed information.
16 We're going to go really high level and look at the big
17 picture here for just a minute.

18 The first is the state budget, and this is a picture or a
19 graph of total state spending from 2001 to 2010, and it shows
20 the total state spending, which includes the operating and
21 capital budgets, but does not include Permanent Fund
22 Dividends. It has doubled from \$4 billion to \$8 billion in
23 ten years. And per capita spending has increased from \$6,639
24 a person to \$11,234 a person. And again, this is operating
25 and capital. So the rate of growth in the operating budget is

1 likely significantly less than this rate of growth, but
2 nevertheless, this is a picture of total state spending. The
3 average is about a 7.5% rate of growth, but inflation over the
4 last decade has averaged 2.6%.

5 The next slide is a slide talking about revenue because
6 we all know where revenue comes from, primarily from oil
7 revenue that flows through the Trans-Alaska Pipeline, and this
8 is -- you know, where does -- sort of what, essentially, is
9 the impact of TAPS? It's about 66% of K12 spending, and for
10 our purposes here, about 90% of state general purpose revenue.
11 Next slide.

12 So on the revenue side, 90% of our revenue that's
13 supporting the budgets that we saw in the initial slides is
14 supported by oil, and this is a graph of oil production, which
15 has declined by just over 5% per year. And there is not a
16 mark on that graph, but if you look -- if you imagine what the
17 350,000 barrels per day mark is, that's the rate at which the
18 pipeline becomes very difficult to operate from a technical
19 standpoint. So we're approaching that point.

20 So where does our current path lead? Even with the very
21 high prices of oil that we have seen, state expenses may
22 exceed revenue sometime in the next decade. You can see below
23 the Department of Revenue oil price projections are between
24 \$95 and \$116 a barrel, and 2001 to 2010 oil prices, the low is
25 a little over \$15 a barrel. The high was \$144 and the average

1 is about \$54 a barrel. So we're extremely vulnerable to
2 changes in the price of oil in an extremely volatile economy
3 right now. And so that's the nature of having that much of
4 our revenue dependent on that one source, and a source that's
5 declining at about 5% a year.

6 So to summarize all that in one sentence, which is never
7 a really good idea, but we have a revenue and we have an
8 expense problem, and health care is a big part of the expense
9 problem and that's what we're going to spend the next few
10 slides talking about.

11 The next slides shows state health care spend and that
12 includes Medicaid, Alaska Care, the Active Plan, PERS/TRS
13 retirees. As you may know, we inherit, as retirees, the PERS
14 and TRS employees from those plans, regardless of their
15 employer. It also includes Worker's Comp, Corrections, and
16 the contributions that we make to the Union Trust. We don't -
17 - not all state employees participate in the Alaska Care Plan.
18 We fund one large, and I think, one smaller Union Trust that
19 actually provides health care. So that's the population we're
20 talking about.

21 In 2001, we paid approximately \$900 million in health
22 care across those groups. By 2010, that number had gone up to
23 \$1.9 billion. And this does include the federal portion of
24 Medicaid, so we did -- it's -- the numbers are overstated for
25 that reason. The rate of growth of state health care costs in

1 that period, 2001 to 2010, was 8.7% per year.

2 The next slide shows you a little more of a breakdown of
3 those different components of the State's total health care
4 spend. The one not on that is the Union Trust. It's -- we
5 can give an estimate, but for these purposes, we didn't
6 include them in that graph. But it shows you where the big
7 bulk of the expenditure is, which everyone knows is Medicaid,
8 but also the significant presence we have as a commercial
9 payer with PERS, TRS, and Alaska Care.

10 COMMISSIONER STREUR: For those of you that can't tell
11 from the slide that's up there, the big wide orange line is
12 Medicaid; it's not Workman's Comp. So I wanted to clarify
13 that real quickly.

14 COMMISSIONER HULTBERG: So asking the same question about
15 where does our current path lead on the next slide, if you
16 take that rate of growth and you project it out to 2020, we
17 are on pace to, again, double our expenditures on health care
18 by 2020. And based on that model, they could exceed \$4
19 billion by 2020 before Medicaid reimbursement and that's a
20 staggering sum when you look at the size of the General Fund
21 budget, and it is completely unsustainable.

22 So if current growth rates continue, health care expenses
23 are going to consume an increasingly large and unsustainable
24 portion of the State's General Fund budget in an environment
25 where we do have some revenue uncertainty, if not today, which

1 we don't today, but certainly in the future.

2 And just to remind us all that there is an opportunity
3 cost of the dollars we spend on health care. When we're
4 spending a dollar on health care, it's a dollar we're not
5 spending on schools. It's a dollar we're not spending on
6 public safety. It's a dollar we're not spending on roads.

7 And finally, I wanted to just give you a snapshot of our
8 Alaska Care Health Plan. These are just some plan statistics
9 in the Active Plan and the Retiree Plan. The thing that makes
10 the Retiree Plan interesting is the benefits are
11 constitutionally guaranteed. So we have very limited ability
12 to impact that plan.

13 And then the final slide we might want to spend a little
14 time on, but really, the question for us is, what can we do to
15 help put the State's health care spend on a sustainable path?
16 It is unsustainable. I can't imagine that, in 2020, we're
17 going to be spending \$4 billion a year of state dollars,
18 excluding the whatever Medicaid is reimbursing at the time, on
19 health care.

20 So what can we do now? Because a decade seems like a
21 long time, but when you're looking at having an impact on a
22 trend, it's not that long. So what we do today can have an
23 impact within a decade.

24 So here are some things that we're looking at: better
25 leveraging our purchasing power, looking at expanded travel

1 benefits or Centers of Excellence for certain services,
2 developing a more robust employee wellness program. We're
3 actually going to be issue an RFP within the next few weeks on
4 an expanded employee wellness program. We're going to
5 continue to aggressively pursue contractual discounts, and
6 where they are available, we're going to try to align our
7 contracting strategies around innovative care delivery models.
8 We have to do something differently. Doing the same thing now
9 will just result in a \$4 billion medical spend in 2020.

10 So the real question for us, the question for you, and
11 really, the question for providers around the state is, what
12 are we going to do differently so that our outcomes are
13 different, because we can't continue down this path?

14 COMMISSIONER LAUFER: Noah Laufer. Do you have any feel
15 for how much of this money goes immediately out of state, you
16 know, retirees and people who live elsewhere?

17 COMMISSIONER HULTBERG: We have -- about 60% of our
18 retirees live instate and so the majority of that money is
19 staying instate, but we do have a number of retirees,
20 obviously, who live out of state. So if you take those -- you
21 know, if you go back to that graph and you look at the
22 PERS/TRS number and subtract about 40%, you can assume that
23 that money probably is going out of state.

24 COMMISSIONER LAUFER: And then on that graph with the
25 red, is that just Alaska's contribution to the Medicaid

1 spending or is that the federal and the state?

2 COMMISSIONER HULTBERG: It's both; yes.

3 COMMISSIONER LAUFER: And the federal is likely to go
4 down is what I understand; is that right?

5 COMMISSIONER STREUR: Federal Medicaid participation
6 right now is at as low as it's going to get, unless the
7 (indiscernible - voice lowered) 12 decides to lower it for the
8 states that have the greatest amount of revenue on the books,
9 and we have the greatest amount of revenue on the books. But
10 right now, it's at 50%.

11 As recently as October of last year, we were at 67%, and
12 you all read about the \$129 million deficit I had. That was
13 what that was related to as a reduction in the aftermath from
14 the Feds.

15 COMMISSIONER HULTBERG: And I think, even if you subtract
16 the federal portion of Medicaid and you look at the magnitude
17 of the dollars that we're spending on health care right now
18 and project it out, I think, even subtracting the federal
19 dollars, we've moving toward a point that really is becoming
20 very difficult to sustain.

21 COMMISSIONER DAVIDSON: So one observation and then a
22 question. So on the slide about opportunity costs, since
23 those are all things that the state budget funds, couldn't you
24 substitute roads, schools, or other public health services for
25 health care, and that statement would still be accurate

1 because that's the full complement of what services the state
2 provides?

3 COMMISSIONER HULTBERG: You're making a good -- you know,
4 you are correct in saying that health care is, in these areas,
5 a fundamental state responsibility and that is not all saying
6 that health care is not a fundamental state responsibility.
7 But if health care is growing at 8.7% a year, it is squeezing
8 out other things as it consumes a larger and larger portion of
9 the General Fund budget. So because of the increase over time
10 in health care, we are currently -- because we are in
11 relatively prosperous times right now, due to the price of
12 oil, it's not apparent, but the concern is, as production
13 continues to decline and as we're increasingly vulnerable to
14 oil price shocks because of the size of our production, that,
15 in an environment of fiscal uncertainty, it will become much
16 more apparent and we don't want the state to be in a situation
17 where we have to make really hard decisions about what
18 services we're going to fund, like they are in other states.

19 COMMISSIONER DAVIDSON: So the other part is, with regard
20 to your last slide, how much of these things are being -- how
21 much overlap is there with the recommendations that just came
22 from the Joint Legislative Administrative Medicaid Task Force
23 and what are the dollar amounts that we're anticipating saving
24 and how do they intersect with this last slide?

25 COMMISSIONER STREUR: Good question. There is some

1 intersection. These are a little broader in what they're
2 saying.

3 In terms of the Medicaid, Medicaid represents, you know,
4 60% of the spend. Mike would know that better than I would,
5 but about 60% of the spend of all health care in Alaska. And
6 the last bullet would be at that level. The bullet right
7 above it, (indiscernible - voice lowered) pursue contractual
8 discount, currently has not been done, but you know, Medicaid
9 pays fairly well in Alaska, and you know, there is that
10 opportunity, if we chose to pursue it.

11 Developing a robust employee wellness program, we need
12 to, as a part of the (indiscernible - voice lowered)
13 contracting strategies around innovative models, develop
14 wellness programs to a greater extent in Alaska. I'm going to
15 say we don't do a very good job on EPSDT for kids, Early
16 Periodic Screening, Diagnosis, and Treatment. We don't do a
17 good job in ensuring that the kids are getting all their
18 immunizations at the right time and right place, and I'm not
19 sure that the greatest preponderance of our care is
20 necessarily the right care at the right time and the right
21 place for the right people.

22 COMMISSIONER DAVIDSON: So then -- I want to stick with
23 that last point on a robust employee wellness program. So if
24 we know that, based upon a prior slide, that shows Medicaid as
25 the red, the largest cost indicator, are you looking at doing

1 wellness programs then for your Medicaid beneficiary
2 population, which you indicated is 60% of the spend for health
3 care?

4 COMMISSIONER STREUR: We have to look at that. It may
5 not be that it will be the same as the employee wellness
6 programs. For instance, we're not going to buy gym
7 memberships and those kinds of things, such an employee
8 wellness program may purchase, but in terms of, you know,
9 offering and encouraging annual physicals, shots, flu shots --
10 we provided adult flu shots last year through the Medicaid
11 program, something that we hadn't done in the past. We need
12 to focus on that. We need to start erecting the fence on the
13 top of the cliff rather than the ambulance at the bottom of
14 the cliff.

15 COMMISSIONER MORGAN: I guess I've got two questions and
16 then an observation. I guess my first question is, under your
17 Retiree Plan, it says limited ability to impact steerage. I'm
18 assuming that you have agreements or the health care benefits
19 and delivery are already set mostly for those Retiree Plan
20 members.

21 COMMISSIONER HULTBERG: Let me make a statement and see
22 if that answers your question. If not, you know, please, you
23 know, ask it again.

24 The issue with the Retiree Plan is it's -- the benefits
25 are constitutionally guaranteed and so the way that's been

1 interpreted is that they are -- that, at the time the benefits
2 were provided, there was no penalty or incentive to use a
3 particular provider. So we may have a discount or a contract
4 in place that members of our Active Plan utilize, and we will
5 still -- in some cases depending on the provider and the
6 contract, we may still get that discount for our retirees, but
7 we cannot, through the plan, provide any incentive or require
8 them to use that contract.

9 COMMISSIONER MORGAN: So basically, you can offer some
10 types of different delivery systems, but you can't -- but it's
11 an option. It is not this is the way we're going to do it.

12 COMMISSIONER HULTBERG: That's correct. We cannot
13 diminish benefits and so something that could be construed as
14 a diminishment could be requiring retirees to use Provider A
15 over Provider B or to pay a penalty if they use Provider B.
16 And so that would be considered a diminishment and so we can't
17 -- but what we can do -- and it hasn't been done, but what
18 could be done is to offer a parallel plan with -- and that's
19 not been done in the past, but I guess the reason I bring that
20 up is to say there are some creative things we could look at
21 and we're going to look at, but the plan, as it exists today,
22 cannot be altered without it -- if such alteration is
23 construed as a diminishment of benefits.

24 COMMISSIONER MORGAN: So basically what we're saying is
25 you can offer some options, some parallel plans, or even some

1 nifty ways of doing it, but it's up to the beneficiary to make
2 that option.

3 COMMISSIONER HULTBERG: Correct.

4 COMMISSIONER MORGAN: Well, fine. I mean, yeah
5 (affirmative). It's not a problem. Just trying to clarify.

6 I guess the second question I have is, especially with
7 Medicaid, we do know because it evens talks about it in this
8 nifty little study -- the Commissioner is already getting
9 ready because he has the answer. I keep asking it, but we
10 basically have about 15% to 20% -- this makes Noah go crazy,
11 but 15% to 20% that basically consumes 85% of the dollars. I
12 haven't -- I think, at the next stage of our statistical
13 pools, we'll kind of get the -- you know, get an idea
14 geographically where they are, but I can guess, you know,
15 mainly in the high population centers. I know, at the
16 Medicaid Task Force that the Commissioner put together, that
17 they were looking at some ideas and made some general
18 observations on some different delivery concepts, or at least,
19 management of that to go that route. Have you looked at
20 actually segmenting your Active Plan members anyway as to, is
21 that percentage -- and I think it does; I'm guessing -- is the
22 same, that you have a 10% or 15% number of the Active Plan
23 members, but they're using 80% of the health care costs?

24 COMMISSIONER HULTBERG: Yes. That's correct, and I
25 couldn't give you the percentages off the top of my head, but

1 we could -- I could find the document.

2 COMMISSIONER MORGAN: No.

3 COMMISSIONER HULTBERG: We have that for the Active Plan
4 and the Retiree Plan.

5 COMMISSIONER MORGAN: No. You don't have to. It's
6 basically in health care that's a truism?

7 COMMISSIONER HULTBERG: Yes. Correct.

8 COMMISSIONER MORGAN: So where I'm going with this is --
9 and this is my last question to the Commissioner and to you --
10 for those where you can do it, have you thought about
11 partnering up with commercial payers or even other delivery
12 systems in the state who may do some of that already of
13 possibly joining forces to concentrate on the 15% or 20% that
14 are using 85% and start getting at the cost of delivering
15 those services, I mean, at least, entertaining it?

16 COMMISSIONER HULTBERG: Absolutely. And I think the last
17 bullet on the final slide was really about looking at
18 innovative care delivery strategies, and we're waiting for the
19 opportunity to do that because we think -- you know, there are
20 new care models out there that can do a better job, I believe,
21 of taking care of that 15% or 20% or whatever it is, so that
22 they don't end up in the emergency room repeatedly, so they
23 don't end up with inpatient admissions.

24 COMMISSIONER MORGAN: I understand that. Bill can tell
25 you I never ask a question unless I know the answer. So I

1 knew -- it looks like, looking at this, that you're going in
2 that direction, but you know, after 15 years, I see a lot.
3 Bill has. We all have. You see these where we say we all
4 know we've got a problem. I'm still Noah's concept. We all
5 know we've got a problem. We all know we've got to do
6 something. And then we have this last page, or usually,
7 there's no last page of some stuff we might do, but at least,
8 you and Bill are the first two people from government that
9 said yeah (affirmative), let's try some stuff of developing
10 some delivery models and partnering up with some non-
11 governmental organizations or non-state government
12 organizations because it just seems like -- and this is my
13 frustration coming out of the -- and I'll say it real low --
14 managed care type activity -- that this is -- the percentage
15 of individuals -- and I'm not picking on them. Nobody is --
16 there are no bad guys here, but that 15%-20% we're talking in
17 Medicaid, 20,000 people, in this probably 4,000 or 5,000
18 people, those are numbers in certain geographic areas,
19 probably Anchorage, MatSu, a little in Juneau, a little -- you
20 know what I'm getting at? That these are manageable numbers
21 that, if we did some stuff or at least started to try to do
22 some stuff, we could slow down, stop, and maybe actually make
23 them healthier or stabilize them and try to get control of
24 some of these costs. And I've heard the Commissioner talk
25 about this, but it sounds like we've all finally got to that

1 point, like Congress, where we're going to have to do
2 something right. Is that what we're -- is that what I'm
3 hearing here?

4 COMMISSIONER STREUR: That is what you're hearing. We
5 have no choice anymore, and getting traction has been
6 difficult. I mean, I'll admit that. But I need to get our
7 partners -- in other words, the health care delivers -- to the
8 table. I need to get the 800-pound gorilla in the commercial
9 market in insurance who is sitting in this room at the table,
10 and you know, we need to get together on this. I use that --
11 at the Medicaid Task Force, I used the phrase that, you know,
12 we can either gore each other's ox or we can sit down and
13 butcher an ox and have a feast. And you know, we can't
14 continue to deliver health care the way we do.

15 To use your statistic on 15% and 85%, 15% consuming 85%
16 of the health care dollar, in Medicaid, I have 5% consuming a
17 little over 50% of the health care dollar. Of that 5%
18 population, some of them are severe chronic conditions that I
19 can't do anything about. You know, I have a young child with
20 immunodeficiency that his prescriptions are \$37,000 a month.
21 You know, we can't do a lot about that, but the other half --
22 the other half of that population, 2.5%, we're just letting
23 them muddle along and that's the best way I can describe it.
24 They're muddling along in the health care system. We haven't,
25 you know, worked with primary care providers, who, I think,

1 are the source and the opportunity that is virtually and
2 totally untapped, in helping us find the solutions and that's
3 why (indiscernible - voice lowered) contract strategies around
4 innovative delivery models. And you know, my constant theme
5 around patient-centered medical home, we've got to begin to
6 get our primary care providers. And sometimes, that primary
7 care provider is a specialist. I'll admit that. I mean,
8 they're in internal medicine. They're a pain medication doc.
9 You know, they are a primary care provider for that
10 individual, but we need to get them engaged so that the person
11 isn't going off getting their gallbladder out when they don't
12 need it and they aren't going off and getting their TBI
13 checked when they don't even have a TBI condition, never have
14 had a TBI condition, but they end up at Duke University
15 because we slipped up and we let them get away. That's -- I
16 mean, that's what we need to begin to do. First, address that
17 5%. Then look at the other 10% because that is part of the
18 solution. But when you look up there at those bullets, those
19 are what we have to do, not what we'd like to do.

20 CHAIR HURLBURT: Representative Keller?

21 COMMISSIONER KELLER: Yeah (affirmative). Dr. Laufer's
22 comment about the Fed reducing their contribution, I would
23 like to get the Commissioner's response. But the dual
24 eligible, the fallback for those that come from the reduction
25 in Medicare fall back to Medicaid and that actually leads me -

1 - am I right? And then that leads me, really, to my question.
2 When I look at your projection on the cost, you know, and I
3 think about the way the federal impact on our eligibility, you
4 know, the increase of the number that has to be covered and I
5 think about the increased obligations that are coming for
6 long-term care, again Medicaid being the biggest payer, the
7 farther I go looking at this -- and you've been responsible
8 for rubbing my nose in it and showing part of it to me -- that
9 seems conservative, I mean. And also, if you put that bottom
10 graph on the top graph, I mean just to give it a little bit of
11 scale, boy, you know, I mean, you're talking the top graph
12 would have to grow three times. It wouldn't fit on a paper.
13 I mean, that's a huge growth that we're looking at, and it
14 just -- the question I really have, does that line reflect
15 those things, the long-term care, increases in Medicaid, and
16 the more people that are going to be eligible, and the
17 Medicare reduction?

18 COMMISSIONER STREUR: What that graph represents -- and I
19 can stand corrected on it, if I misunderstood it, but I
20 believe it's almost a straight line projection of the status
21 quo. So it doesn't include the 32,000 additional Medicaid
22 recipients who become eligible on January 1, 2014. It doesn't
23 include the Medicare reductions. A lot of us are saying hold
24 it, hold it, hold it, you know. A Medicare reduction,
25 particularly for the billed coverage, is going to fall to

1 Medicaid, but there is another consideration with the Medicare
2 recipients who face a reduction. Some of those then, as a
3 result of that Medicare reduction, will fall into the dual
4 eligibles. And nobody -- that's the 800-pound gorilla that
5 nobody is talking about in the room.

6 CHAIR HURLBURT: Linda?

7 COMMISSIONER HALL: This chart that is the second to the
8 last slide that shows ability to impact steerage and limited
9 ability, do you have the ability to impact steerage in
10 Medicaid?

11 COMMISSIONER STREUR: Yes.

12 COMMISSIONER HALL: So creative innovative programs in
13 the bottom of this could be applied to that very large
14 Medicaid portion?

15 COMMISSIONER STREUR: Medicaid already does a lot of
16 steerage. Before I'll travel anybody, I have to -- we run
17 them through, basically, a screening to make sure that service
18 is not available in their home community. So that is already
19 happening. Do people get away? You bet. You know, when
20 Representative Keller picks up and calls me, my poor recipient
21 up here in the Valley doesn't like to go Anchorage for their
22 care and they have this great program at Duke University, can
23 you please let them go there, some of the time, they are going
24 to get there. But no. It's a bit tongue-in-cheek. He has
25 never done that to me, but there is.....

1 (Pause - background noise)

2 COMMISSIONER STREUR: He's thinking, did I do that? I
3 can't remember. But seriously, we have much more opportunity
4 in Medicaid to do that, but the serious part of that is that,
5 when I do that, there is, generally, a reaction to it. And
6 you know, if I don't have Representative Keller calling me, I
7 have Representative Chenault calling me, you know. And so
8 then we sit down and we talk about it, and it's -- Medicaid in
9 Alaska has almost as great a hill to climb as our commercial
10 insurance products for state employees. That, you know, we
11 have always been every dollar, every time, every service, you
12 know, whatever they need. And I can't stress enough we need
13 to redirect it so that we're doing more at the front end, so
14 we don't have to do as much at the back end.

15 Prenatal care. I need to ensure prenatal care for as
16 many Medicaid recipients as I can because the idea that a
17 challenged birth is \$100,000 expense is long gone. A
18 challenged birth is now a million dollar expense, and we don't
19 need that because many of those end up being Medicaid
20 recipients for the rest of their lives, SSI and everything
21 else.

22 COMMISSIONER HALL: Did I understand you -- thank you for
23 letting me follow-up. Did I understand you answer
24 Representative Keller's question, this graph that goes up to
25 \$4 billion does or does not include some anticipated long-term

1 care, which in the world I regulate, has become
2 extraordinarily expensive? So I'm just interested whether
3 this includes potential long-term care, which I see as
4 incredibly growing expense.

5 COMMISSIONER STREUR: The graph that's in front of us is,
6 if the existing Medicaid spend remains as it is -- in other
7 words, we don't change benefit coverage. We don't do
8 something to intervene. We don't move toward patient-centered
9 medical home. We don't move toward chronic care management.
10 It's assuming that the status quo, the way we deliver care
11 right now, so it does not anticipate catastrophic significant
12 long-term care.

13 COMMISSIONER HALL: David just handed me an *Alaska*
14 *Economic Trends* which shows, from 2010, the population of
15 senior citizens at 55,000, growing in 2030 to 124,000. So I
16 mean, we're talking 150% growth, and a good number of those
17 people, ultimately, will need long-term care.

18 COMMISSIONER HULTBERG: And just to kind of elaborate on
19 the genesis of these charts, we really just went back to the
20 CAFRA and pulled those numbers and projected them forward. So
21 you could do a lot more, I'm sure, sophisticated modeling to
22 include those numbers that would likely change that chart in
23 an upward direction for the worse, but this was just, what has
24 been our trend, based on audited numbers, and if that trend
25 continues, what does it look like in ten years?

1 COMMISSIONER HALL: Thank you.

2 CHAIR HURLBURT: Noah or Val?

3 COMMISSIONER DAVIDSON: So what is our long-term care
4 plan?

5 COMMISSIONER STREUR: I have no idea. No. I don't know.
6 I mean, that is serious. I think that we need to continue our
7 home and community-based services, but we need to develop them
8 around a logical, thoughtful, well-controlled model, and we
9 don't have that right now.

10 COMMISSIONER DAVIDSON: So when might we have that?

11 COMMISSIONER STREUR: When all our provider partners join
12 with us in coming up with that, the IHS services, our
13 hospitals, ASHNHA, ASTHMA, APS, and Blue Cross and the other
14 payer network. It's the same story for long-term care as it
15 is for general care. All of them are unsustainable. And home
16 and community-based services is supposed to save a whole lot
17 of money. On a per capita basis, Alaska is spending more on
18 home and community-based services than nearly every other
19 state in the nation, and we're a relatively young home and
20 community-based services state.

21 COMMISSIONER BRANCO: Commissioner Streur knows that the
22 Hospital Association is really committed to making this work
23 today and into the future, long-term care and the provision of
24 health care to our communities that we serve. We're in a bit
25 of an unusual position -- or it's not that unusual -- with the

1 State as a payer trying to reduce costs. The hospitals and
2 nursing homes are looked at as a cost to the system. The
3 provision of care, the continuation of the provision of care
4 is a cost to me. I have not met many physicians, other than
5 the three in this room, who would willingly take salary
6 reductions to continue to work on their good graces. However
7 -- or CEOs who would be willing to reduce their salaries.

8 So it's going to become quite a complex task to reduce
9 the costs it takes me to provide care. We're going to shift
10 the manner in which we deliver care to the lowest level and
11 most effective level, so more outpatient services, more
12 reliance on primary care, but I'm deeply concerned that, if we
13 do it too fast by forcing the condition -- so if the State
14 reduces reimbursement to me, my reaction won't be a careful,
15 methodological change and shift in the manner in which I
16 provide care. What we'll end up with is a trap into the
17 traditional cost shift. So if I'm still expected to provide
18 care with the same model and I have one payer reducing
19 payment, it always shifts and I, for one, don't want to see
20 that happen.

21 CHAIR HURLBURT: Allen, did you have a comment?

22 COMMISSIONER HIPPLER: I did, but I'm willing to wait.

23 CHAIR HURLBURT: You're next, next in line.

24 COMMISSIONER HIPPLER: Is it Becky? Okay. I have a
25 question about the fundamental understanding of the State's

1 role in health care. I'm a little -- I'm new to the
2 Commission, so I'm still getting used to this.

3 You had stated that health care is a fundamental state
4 responsibility. Are you referring to health care for the
5 employees of the state of Alaska or for all citizens in the
6 state of Alaska?

7 COMMISSIONER HULTBERG: I was referring to the
8 populations we're talking about in this presentation.

9 COMMISSIONER LAUFER: This discussion relates to, really,
10 all of the preceding discussions. Basically, anybody who
11 falls out of the system, whether you are old enough or sick
12 enough or poor enough, becomes the State's responsibility. So
13 the State is, ultimately, responsible for all the highest
14 risk. If you're born, you know, with hemophilia and it's
15 going to cost a couple hundred thousand a year, the only
16 entity that will take over your care is the State.

17 To me, you know, when we look at these curves and
18 projections that are logarithmic and straight up, and by 2020,
19 it's going to be infinity, those aren't sustainable and that's
20 why, I think, we're asking the wrong questions, like in the
21 Milliman study. We need a paradigm shift, a huge shift, and
22 to me again, it comes from a new way of thinking, and this --
23 there are entities that are starting to be born now, like
24 narrative medicine. And this is, you know, in the context of
25 your life, you are the writer of the story of your life. How

1 are things going? Are you the hero? How's that alcoholism
2 working out for you? You know, because just bumbling along
3 and getting millions of dollars of high tech procedures
4 doesn't provide a quality of life, and you know, there are --
5 what is it? Bhutan has a Ministry of Public Happiness. You
6 know, I'm not proposing that, but that's really the question.
7 I'll start to sound like I'm Swedish or something, but you
8 know, what is your quality of life? That's why I asked and
9 was a pain-in-the-rear about, you know, well, what do you mean
10 by health or what do you mean by mortality? My mortality rate
11 is 100%. But it's my belief -- and this is idealistic, but
12 you can be in the last day of your life, you know, dying of
13 something and still be healthy, if the narrative of your life
14 is one that is acceptable to you, and we can help people with
15 that and that's the tool, when my fantasy deputized team of,
16 you know, a deputized Medicaid doctors show up and say, you
17 know, the State has spent a lot of money on you. You have a
18 social contract. I'm here to help. I've got a, you know,
19 substance person, a behavioral health person, you know, a case
20 manager person, and we want to help you. You've risen to the
21 level of need. That's what we need. How is the narrative of
22 your life going? Is this acceptable to you? Do you want to
23 change it? And this is a very different view, but it's the
24 answer. And I don't know how to implement that, but that's
25 where it is. If it works, the hospital will have a much

1 smaller census, things cost less, and you know, you face the
2 end of your life; maybe I don't want a million dollars spent
3 on me because I'm dying of pancreatic cancer. I can live with
4 that. But we have to change the vocabulary and language of
5 what we're doing. Sorry.

6 COMMISSIONER STREUR: May I respond to a couple of these?
7 I'll start out with Dr. Laufer's. I don't disagree with you,
8 but we have created a society that thinks just the opposite.
9 I want all the care I can get at the time when I want it. You
10 know, it's -- Dr. Stinson sees it all the time and has to say
11 no. You see it all the time and have to say no. I talked to
12 some physicians. I said, you know, why did you write that
13 prescription for that individual? I just wanted to get them
14 out of the office. They were insistent on it. They found it
15 in *Good Housekeeping*. They swear that that's what they need
16 to get better, and it's to get them out of the office. And
17 changing that, I don't deny, needs to happen, but the
18 individuals are not going to change it as quickly as we need
19 to change it. It's not going to happen by 2020. You know, we
20 need to do it. And so it's physicians and other care
21 practitioners getting involved. It's we leading them and
22 saying, you know, learn to just say no. Use Nancy Reagan in
23 slightly a different context here and moving it forward. But
24 it's very, very challenging, and I guess what I'm looking out
25 for is taking tools that we have available to us now, taking

1 the opportunity that we have available to us now, and sitting
2 down as care providers and as payers to come up with solutions
3 for this thing.

4 COMMISSIONER LAUFER: Along those lines, say you have one
5 of your 2.5% super high utilizers who there is room to improve
6 on, the way it is now, that person is in my waiting room, and
7 we do see some of those folks. They are creating a scene.
8 They have a personality disorder. They don't smell good or
9 whatever. I have other patients who don't like that. I'm
10 poorly reimbursed for them. They are very high difficulty for
11 me to care for. I don't have any of the resources I need to
12 really address that, and if I have, you know, an Accountable
13 Care Organization watching me, they are making my statistics
14 look bad, and you know, it's just a loss.

15 You know, I'm afraid I shouldn't say this, but I did have
16 a Medicaid patient who insisted on going to Seattle and got
17 all the paperwork, and she came back, and I said, how did it
18 go? She said oh, I didn't see the -- she never went to see
19 the doctors. She took a free vacation on Alaska. She didn't
20 like them. The receptionist was rude or something. It's
21 tough, tough, tough, and you need more resources.

22 COMMISSIONER STREUR: And my attorney says I can't throw
23 them away. I've got to find the resources to support them, in
24 spite of their behavior.

25 CHAIR HURLBURT: Val?

1 COMMISSIONER DAVIDSON: So I haven't said this for a
2 while, for at least two years, but I'm going to say it again.
3 The one thing -- the one question we don't ever ask at a
4 primary care visit -- if I go in, I have strep throat or I go
5 in and my kid has an ear infection or whatever it is, at the
6 time that person presents, the one question we never ask is,
7 if you could improve one thing about your health over the next
8 year, what would that be? And then develop a plan to go there
9 because, even though I may be seeing a doctor because I have a
10 sinus infection, my sinus infection is temporary, but maybe my
11 issue is I'm chubbier than I should be or I've got a drinking
12 problem. I'm definitely chubbier than I need to be, but I
13 don't drink, so that's not my issue. But I mean, even I --
14 just as sort of a point of reference, I asked my question to
15 my daughter once who had been in the hospital five times in
16 five years because she had RSV when she was eight months old.
17 She's forever going to have a compromised respiratory system.

18 At one time, she was on five different medications. And
19 what we were all doing for her was very different, and I asked
20 the question one day as we were leaving. And I said, you
21 know, if you could change one thing about your health over
22 this next year, what would you choose? And her answer was, I
23 want to be able to run as fast as the other kids at recess.
24 And for her, that shift of -- it completely changed my
25 perspective of what is it that we're doing -- and I mean, I

1 could explain all of the reasons why she needs to take her
2 allergy medicine, why she needs to use her inhalers, blah-
3 blab-blah-blah, but until I put it into terms that she
4 understood as a six-year old of we're doing these things, so
5 that you can run as fast as the other kids at recess, we're
6 just not going to get there.

7 And the challenge is -- to go to Noah's comment -- that
8 we don't incentivize those kinds of conversations because that
9 person is there for a strep throat or they are there for an
10 ear infection and that's what we're going to do, by gosh. And
11 so I'll stop.

12 COMMISSIONER STREUR: I don't disagree, but you know,
13 you're not there yet. But for some us, as we get older, we go
14 into a doctor's office and they don't dare ask us that
15 question.

16 COMMISSIONER KELLER: In a sense, what you described,
17 Val, is my ideal of what a patient-centered medical home does.
18 I mean, you are describing process, but with the concept.

19 CHAIR HURLBURT: It really is inherent in your last point
20 on your last slide there with alternative delivery systems. I
21 think it's probably inherent in that, too, but Bill would be
22 surprised if I didn't say it.

23 I think one of the things -- where one of the real
24 opportunities we have -- and it relates to a presentation to
25 the Health Care Commission before I came on, before most of us

1 in this room did, when it was enlarged, but in the first
2 meeting or two, there was a presentation basically saying --
3 and you would be familiar, with your background -- that 35%-
4 40% of the care that's provided through our health care system
5 is not really supported by high grade evidence. And when you
6 have a \$2.75 trillion business in this country, that's a lot
7 of money, and it's difficult to deal with. I think you deal
8 with it in two ways.

9 One is from the payer side, where, in both your benefit
10 design and your (indiscernible - voice lowered) process you
11 use those principles, but it also has to be applied at the
12 encounter between the provider and the patient, where there
13 always has to be some tailoring of that to the patient there.
14 But when you think about the dollars that we're talking about,
15 that's huge.

16 I have a saying pasted up on my wall downstairs that I've
17 used here as a slide with the group that, historically, we
18 assumed, after you went through all your years of college and
19 medical school and residency and did your reading and kept up
20 your CME and did all that, that you had the expertise and you
21 really can't now. No single provider can do that.

22 We gave Bill a copy, and we made available to all the
23 Commissioners. This is not a quick read. There is a John
24 Wennberg, whom you may have heard, who started out in Vermont,
25 but showing huge differential rates of TNAs for schools 20

1 miles apart, just based on who was a school physician or was
2 there an otolaryngologist there or something. But I think, in
3 the points that you make, the concepts that show amazing
4 differences in rates of hysterectomies or radical
5 prostatectomies or one thing or another that, you know, can't
6 be defended by the high grade evidence have to play a part in
7 what we do because controlling costs can be consistent with
8 improving quality, I believe.

9 COMMISSIONER HULTBERG: Just to add to that, things that
10 weren't on that list but are concepts that we would be looking
11 at through any of these strategies: transparency, helping our
12 plan members become better consumers of health care through
13 transparency of quality data and transparency of pricing. And
14 that's very easy to say and I recognize it's very hard to
15 implement, but the more we can help people become more engaged
16 in understanding what the difference is between Provider A or
17 B and enable them to make that choice, I think the better --
18 the more we'll help them avoid, potentially, unnecessary
19 procedures and have some impact on costs that way. But again,
20 I mainly wanted to mention it just because those are things
21 that are not explicit in that list, but I think are things
22 that, as we look at how we might have an impact, are very much
23 at the forefront.

24 COMMISSIONER STREUR: And I wanted to expand on that just
25 a little bit. There are only six items on that list, but take

1 a look at that. There is so much more that is not said and
2 capable through that and so I mean, ask that you use your
3 imaginations help us move this forward.

4 There is no single magic bullet in this. You know, it's
5 not just the providers. It's not just the payers. It's not
6 just the recipients or the consumers; take your pick. It's
7 everybody getting together. Does primary care need to be
8 involved? Yes, whatever that primary care level is. Do
9 hospitals need to be involved? Yes. A combo of care
10 organizations is not going to do it and that's what I want to
11 emphasize is there is no magic bullet. It's going to take all
12 of us sitting down, transparency, openness, looking at
13 sacrifices on everybody's parts because, otherwise, it's going
14 to be done to us one way or another and that's not a threat.
15 I think it's reality. When you look at the graphs, when you
16 look at the charts, when you look at the Medicaid spend, you
17 know, I cringe at that because I've got to go represent an
18 additional \$200 million for this coming year for the state of
19 Alaska. Well, I have 130,000 that are Medicaid recipients.
20 You know, if Jeff takes 130,000 people that are enrolled in a
21 plan and he's got to come back to them with a \$200,000
22 increase every year, that's not sustainable. And I mean, so
23 we've got to find solutions, and we've got to get together.
24 We've got to partner on this thing, and we've got to make some
25 sacrifices.

1 COMMISSIONER CAMPBELL: The question is, who is going to
2 be the convener of this round table? Who's got the muscle?

3 COMMISSIONER STREUR: Is it the muscle or who is stupid
4 enough to take it on? I think the reason Commissioner
5 Hultberg and I are here in front of you today is that we feel
6 that we need to be leaders in helping this move forward and be
7 precipitants of getting people at the table. I'm going to get
8 in front of ASTHMA -- we are going to get in front of ASTHMA
9 in the next few months, and I want to sit down with them, and
10 I want to sit down with the Hospital Association and others,
11 and you know, grind through some of this stuff. You know, I'm
12 old, but I'd love to go out with this. You know what I mean,
13 Keith. But I'd love to go out with this as being something
14 that we have designed for the state of Alaska beyond 2014,
15 when a lot is going to happen.

16 COMMISSIONER CAMPBELL: Then I suggest that we try to
17 come up with two or three consumer groups, at least, people
18 delegated from some of these groups to sit right there with
19 you guys. They're going to have to jump off the cliff with
20 everybody else.

21 COMMISSIONER MORGAN: This will shock you; I agree,
22 Commissioner. I actually -- I had hoped, originally a year
23 ago, because I do sound like a broken record; you can ask
24 everyone here. I am consistent, but I'm constantly
25 consistent. I was hoping, and I think it will evolve, that

1 the Commission, itself, would also be involved in this. I,
2 and several of our members, have joined or go to a lot of
3 different meetings from MGMA to Primary Care Association to
4 others. We still are siloed pretty good, but I think it would
5 behoove us all to try to go outside of our comfort zone and go
6 into some of these meetings. You know, primary care
7 leadership maybe should sit with the Hospital Association. I
8 think we need to get -- I think how this commission or
9 coalition is put together is a way to approach this. I don't
10 think that Commissioner Streur or the Commissioner of
11 Administration can carry this full load.

12 I think it's going to have to be leadership in these
13 organizations that we represent, plus some consumer
14 organizations, but also Commission members and the public.
15 But if we're going to get something done, time's up. I think
16 we're going to have to start moving in that direction from
17 Commonwealth North to all these organizations. And maybe we
18 should all have just an offline strategy session of looking at
19 the calendars of when all these other activities are going and
20 being there. I go to some of these, and I know you go, and I
21 know you guys go, and a lot of people come up and talk to me
22 that you would naturally think are hardened in being
23 advocates, but they're willing to be reasonable, if everyone
24 will be reasonable. And so I think that we need to ponder
25 that and compute that through, and maybe sometime while we're

1 doing these recommendations, that we need to partnership up.
2 I just don't think you guys can carry this whole load.

3 COMMISSIONER STREUR: We don't plan on it. I see us more
4 as a cheerleader role, you know, getting it started,
5 challenging, but no. I think I've said that a couple of
6 times. It's going to take everybody in this room. It's going
7 to take every organization sitting behind us and in front of
8 us. It's not going to be painless.

9 CHAIR HURLBURT: And it's not static right now to
10 question those of having it convene or when do we get started.
11 To make a task force team up with some recommendations that
12 health care services is in the process of implementing --
13 we've been paying average wholesale price, minus 5%, for
14 pharmaceuticals. That's a sugar daddy price to pay, but that
15 methodology is being changed, and the pharmacists and health
16 care services are working on that.

17 So I think I'm absolutely agreeing with what you say and
18 what Keith said, but things are happening now. There is so
19 much that needs to happen. Wes, did you have another comment?

20 COMMISSIONER KELLER: I just want to go further over part
21 of what Dave did. I think it was the perspective or the
22 understanding and the realization that has grown on us over
23 the last three or four years that we have an unsustainable
24 question in mind that created this Commission, and it's pretty
25 safe for me to say because Linda and I don't have to vote, but

1 you know, it's a tough calling. And I really think it's
2 something that -- as I look around at the different groups,
3 this is the group that is -- in my opinion, you know, and I'm
4 not talking about me. I'm talking about you, the group here.
5 I'm with you, but we're in a better position than anyone in
6 the state right now to do this. For one thing, you know,
7 we're talking money.

8 As I drive through my district out in the Valley and I
9 see all the new construction happening around me and I look
10 and I observe, guess what? It's all health care stuff, you
11 know. So to say no, you know, that's tough stuff. You get --
12 it's tough stuff. And so -- but -- so I don't see -- my point
13 is this -- and I don't mean this to be really judgmental
14 toward the provider group at all, any provider group, but we
15 can't expect them to carry the load, you know, the providers
16 as a whole, the providers in this group. You can do it, but
17 so anyway, I go farther than what Dave did and say, you know,
18 in some sense, I mean, it's not just an opportunity on the
19 table. It's our job.

20 CHAIR HURLBURT: Any other comments? We're at the end of
21 our time, but we very much appreciate your coming, appreciate
22 what you're doing, your recognition of the issues and the
23 problems, and working on them on behalf of the Health Care
24 Commission, but working on them on behalf of Alaska and
25 Alaskans, and so thank you. And we'll look forward to maybe

1 having you all come back again sometime.

2 COMMISSIONER HULTBERG: Thank you. It was a pleasure to
3 be here.

4 CHAIR HURLBURT: Thank you.

5 COMMISSIONER STREUR: Thank you.

6 CHAIR HURLBURT: Andrea, are you on the line? Are we in
7 lecture mode? I think we can probably go ahead and wrap up
8 then. Andrea Fenaughty was going to talk about some of the
9 things that we have been doing related to data capture. It
10 was going to be pretty brief. She's down in Juneau and was
11 going to call in, and we can reschedule that now. Deb?

12 COMMISSIONER ERICKSON: Yeah (affirmative). And
13 actually, I could have -- we can just get a real brief written
14 report or I could just update you all tomorrow real quickly.
15 She was just going to update you all on the status of the
16 implementation of IBIS Public Health. That's the Community
17 Indicator System that you all had started off making a
18 recommendation about a while back, and just by asking the
19 question, got some momentum, and they're ready to implement
20 the first phase and have it go live at the end of this
21 calendar year, and she was just going to update you all on
22 that. So.....

23 MS. FENAUGHTY: Can you hear me?

24 COMMISSIONER ERICKSON: Oh, she's here. We're going to
25 get that update real quick.

1 MS. FENAUGHTY: I'm sorry. I was listening, and no one -
2 - I had to redial in.

3 COMMISSIONER ERICKSON: That's okay. Two minutes.

4 MS. FENAUGHTY: Two minutes?

5 COMMISSIONER ERICKSON: That's it. Welcome, Andrea.

6 MS. FENAUGHTY: Really quickly, thanks very much for the
7 chance to update. So current status, our in-house IBIS
8 expert, Charles Utermaul (ph), has been super busy working
9 with the Utah Department of Health folks, and they've been
10 working with us providing technical assistance. So basically,
11 we've got the statistical and the web software that we need up
12 and functioning, which is good news. Remember, IBIS has two
13 parts, one part is the static set of indicator profiles, and
14 the other set is the query system. Both are moving forward,
15 and we anticipate, by January of next year, we will have, with
16 our BRFSS data, IBIS launched publicly. And I'll be giving a
17 presentation of that at the Health Summit in January.

18 Again really quickly based on where we are now, our next
19 steps, they're sort of what we know for sure and what we hope
20 for. What we know for sure is, following the BRFSS part,
21 we'll be adding the Youth Risk Behavior Survey, or the YRBF
22 data, in the spring of 2012 and that gives us statewide data
23 about high school students on risk behaviors.

24 Following that will be cancer registry data, and those
25 are all the data sets that are housed with us so that we have

1 direct control over it. It is our hope that then following
2 will be trauma registry, hospital discharge data, and even
3 reportable diseases, other data from the Division, and
4 possibly even Medicaid data in the years to come. So that's a
5 quick two-minute update.

6 COMMISSIONER ERICKSON: Thank you very much, Andrea.
7 Does anybody have any questions for Andrea? No questions
8 here. So thanks very much for calling in.

9 MS. FENAUGHTY: You're welcome. Thank you.

10 COMMISSIONER ERICKSON: Is it okay with you if I wrap up
11 real quick, Ward?

12 CHAIR HURLBURT: Yeah (affirmative).

13 COMMISSIONER ERICKSON: I just pulled out this slide. I
14 found the presentation from -- are we getting some feedback on
15 the system? Is it -- Andrea, are you still on the phone right
16 now? Why would it be giving us feedback though?

17 CHAIR HURLBURT: Maybe Andrea, could you press mute, if
18 you're on?

19 COMMISSIONER ERICKSON: Or hang up and call back in
20 without the speaker code. I pulled up this slide that we had
21 used to -- I'm having a hard time with the feedback,
22 listening. Sorry. But we (indiscernible - recording
23 interference). It's going. I know. It's only going to get
24 worse. I'm trying to give you guys -- you know, I'm trying to
25 give you homework for tonight. It's just not meant to be.

1 I just wanted to set the stage for our presentation for
2 tomorrow morning and to bring some context to what we've been
3 talking about today. This is the slide that we used this past
4 fall to select the strategies to help drive value as the way
5 to improve costs. I mean, that's what we were coming to
6 learn, as we know that the system isn't sustainable. We
7 wanted to continue studying costs and get a better
8 understanding of pricing and reimbursement in this state, so
9 that we're well-informed in moving forward with making some
10 policy recommendations, but that, all around us, we know that
11 the way we're going to make this system more sustainable is to
12 improve value in the system and improve quality and
13 efficiency. And so these are the strategies that we had
14 considered, and we had already focused on primary care
15 innovation, but this group wanted to spend more time
16 understanding better the innovative models that are being
17 tested and that are being successful around patient-centered
18 medical homes, patient-centered primary care. So we've spent
19 part of the year doing that, diving into that a little bit
20 deeper.

21 There are materials on price and quality transparency,
22 and we learned more about the all payer claims database today,
23 partly related to the price and quality transparency, as far
24 as they are statewide data systems that are being used to
25 support that. That is one of the models. But included in

1 that section in your notebook, really, two sets of background
2 materials, one on price and quality transparencies, and I
3 tried to pick some that show some of the things that we should
4 be cautious about, not just the complexity, but some other
5 challenges related to that and not just the technical issues
6 either. So if you haven't yet, over the past week, had a
7 chance to review those, you might want to, but then the other
8 set of materials were directly related to state health data
9 systems and some specific information about hospital discharge
10 and all payer claims databases.

11 So tomorrow during our discussion time -- we have two
12 hours for discussion -- we can spend some time talking about
13 price and quality transparency. We also have on our agenda to
14 spend some more time, if we need to, talking about Health
15 Information infrastructure, and specifically if you want to
16 talk more about all payer claims database or hospital
17 discharge data, we can do that, talk about next steps related
18 to that.

19 Our presentation tomorrow morning is about -- I invited
20 Professor Miller to present to us because he is a national
21 expert on payment reform, and he's going to educate us about
22 bundled payment systems, but talk more about the context of
23 what we need to do to understand how health care is paid and
24 what we could do to work at a local level to support moving
25 towards the new payment methodologies.

1 I had invited Commissioner Streur and Commissioner
2 Hultberg to come talk with us today, specifically because we
3 had identified last fall an opportunity for driving value
4 through payment reform through leveraging purchasing power,
5 and specifically maybe as a first step, what could we do to
6 leverage state purchasing power. I asked them if they'd be
7 willing to do that, and they said well, we're already talking
8 to each other. We're already working on a presentation. So
9 the timing was really ripe for that.

10 So I just wanted to provide some context for that. We'll
11 have two hours to talk tomorrow after Professor Miller's
12 presentation about next steps, potential findings and
13 recommendations around each of these areas. Any questions
14 about our plans for tomorrow? We're going to start promptly
15 at 8 o'clock. So try to get here by 7:30, if you can, Jeff.
16 I would tell you, you could bring Blake with you, but we won't
17 do that. I say him flying the kite earlier.

18 So we are actually webinarizing the presentation.
19 Professor Miller will be participating from Pittsburgh and
20 making the presentation that way. He won't be able to be with
21 us in person, but he will be live.

22 Any questions about today, tomorrow, our discussion
23 plans? Thank you all very much for your time and attention
24 today and all your hard work. You may leave your binders on
25 the table.

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