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ALASKA HEALTH CARE COMMISSION

FRIDAY, AUGUST 26, 2011

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1 I'd like to welcome everybody here again, both the
2 Commissioners and those in the audience and those that are
3 calling in online. I think we had a good day yesterday.
4 Really appreciate everybody's active participation in that.

5 This morning, we have a presentation by Professor Harold
6 Miller whom I've not had the privilege to meet, but I've seen
7 some of his stuff online. Deb has talked with him quite a
8 bit, and we'll let Deb do the final introduction for him here
9 this morning. But we're going to be talking about alternative
10 payment mechanisms and some things that are being done around
11 the country.

12 Professor Miller is one of the real national experts and
13 has spoken widely on this. I've seen his presentations that
14 have been online. I think it's going to be a treat for
15 everybody here.

16 And then we're going to have the Reactor Panel
17 afterwards, after the presentation to talk about some of the
18 things that Professor Miller is going to present to us here.

19 So I think we have a good morning and then we'll have
20 about two hours for discussion. As you noted yesterday, Deb
21 was very careful to build in more discussion time than we've
22 had in other meetings in response to the constructive and
23 appropriate requests from all of the members of the Commission
24 here. So I think we'll have an exciting day, and Deb, if I
25 can turn it over to you?

1 COMMISSIONER ERICKSON: Sure. What I -- just for folks
2 in the room, we set this up a little bit at the end of the day
3 yesterday, but just as a reminder for our Commission members,
4 one of the strategies that we're studying this year is payment
5 reform and two aspects of that that we specifically wanted to
6 study this year were payment bundling and also opportunities
7 for leveraging purchasing power through multi-payer
8 approaches.

9 And so as Dr. Hurlburt was just saying, I actually just
10 kind of stumbled across Professor Miller's work online. It
11 seemed very aligned with the strategies we've been talking
12 about, and as I had an opportunity to ask folks from different
13 states who have been working on innovative programs in some
14 other national organizations, initially, do you know anything
15 about this guy and also just who is the expert in this, I kept
16 coming -- all roads led back to Professor Miller, who is
17 an.....

18 MR. MILLER: Would you quit calling me professor?

19 COMMISSIONER ERICKSON: Yes, sir.

20 MR. MILLER: I'm Harold.

21 COMMISSIONER ERICKSON: Harold. Harold is a Professor of
22 Public Policy and Management at Carnegie Mellon University in
23 Pittsburgh, and he's also the President and CEO of the Network
24 for Regional Health Care Improvement and the Executive
25 Director of the Center for Health Care Quality and Payment

1 Reform. And you all have a copy of his bio in your notebooks,
2 the Commissioners should, and there are also copies in the
3 back of the room, for folks in the audience. And I just
4 wanted to mention, too, one more logistical point for folks
5 who are listening over teleconference this morning. If you
6 did not register for the webinar and aren't watching the
7 webinar on your computer but are at your computer, we do have
8 this presentation posted on the Commission's website on the
9 August meeting page with the presentations and handouts. So
10 you could follow along that way, if you choose to. But all of
11 that being said, I'll go ahead and turn it over to Harold.

12 MR. MILLER: Thank you, Deb, and hello, everybody. Can
13 everybody hear me okay?

14 COMMISSIONER ERICKSON: We can hear you.

15 MR. MILLER: Am I getting nods?

16 COMMISSIONER ERICKSON: Yes. Yes. We can hear you
17 great.

18 MR. MILLER: Since none of you can see me, I will tell
19 you, given the context earlier, I am not obese. So if you're
20 developing an image in your mind of what I like, you don't
21 have to. You can imagine not exactly the most physically fit
22 person, but I am not obese. So you can sort of think about me
23 as being in the middle.

24 But I really appreciate the opportunity to talk to you
25 all about ways that, particularly through payment reform and

1 some other issues that I'll talk about, you can, hopefully, be
2 able to move your health care delivery system in Alaska to
3 even higher value than you have today, and I think that this
4 is very timely, given all of the kinds of things that are
5 going on at the national level as well as in other parts --
6 places around the country.

7 And I'm going to start with this notion of Accountable
8 Care Organizations that has been talked about in health care
9 circles over the past year, and I'm starting with it not
10 because I think it's the right way to do things, but because I
11 think that the way it's been approached is exactly the wrong
12 way to do things and that there are some lessons in that.

13 If you -- there has been constant (indiscernible - voice
14 lowered) around the country. Medicare has regulations, draft
15 regulations out about this, and if you go to the conferences
16 and you read the (indiscernible - voice lowered), what you see
17 is lots and lots of discussion about how much financial risk
18 health care providers can take and who should be on the board
19 of the Accountable Care Organizations, but what they don't
20 talk about is, what's actually going to happen inside this
21 Accountable Care Organization, ACO, thing that's actually
22 supposed to produce lower costs for the patient?

23 And I think that the place we should be starting is not
24 with risk and organizational structure, but talking about how
25 care is going to change, and if we don't do that up front,

1 when the patients find out about these kinds of things we're
2 investing, they're going to think that what's happening in
3 that black box is rationing of care and that could end up
4 really -- operating against our success, and I think that is
5 one of the things that happened in the managed care efforts of
6 the 1990s was that too much effort was spent on trying to
7 simply reduce costs without thinking about how to reinvent
8 care.

9 So I think (indiscernible - voice lowered) is that where
10 we should be starting it to say, how do you actually change
11 the way care is delivered, so that it reduces cost without
12 taking away from anybody the care that they really need to be
13 able to get healthy and remain healthy?

14 I've been surprised, in traveling around the country, at
15 how many people think that there is no way to do that, that
16 the only way you're really going to reduce cost is by taking
17 things away from people, and I don't buy that. I think there
18 are three major ways that you can reduce costs without
19 rationing.

20 One is by keeping people well. If they don't get sick,
21 they don't have health care costs at all. Second is, if they
22 do get some kind of a health problem, particularly chronic
23 disease, which is one of the major cost drivers in America
24 today, that we help them manage that health condition in a way
25 that reduces the frequency with which they have to be

1 hospitalized or have other kinds of acute care episodes. And
2 if they then need to be hospitalized or get major acute care,
3 that that gets delivered in a way that doesn't have
4 complications, infections, and readmissions, which are
5 happening at very high rates around the country, and that that
6 care gets done as efficiently and successfully as possible.

7 Now the good is that all of those approaches can save
8 money, but they're also actually quality improvements, and I
9 think that, if we were telling the American people and the
10 residents of Alaska that what we were trying to do is to help
11 them stay well, to help them stay out of the hospital, if they
12 don't need to be there, and to make sure that they have an
13 efficient, successful outcome whenever they do go to the
14 hospital, I think that they would probably say that sounds
15 like a pretty good idea to them. So that, to me, is sort of
16 what we should really be trying to focus on here is to be able
17 to improve quality in a way that actually reduces costs.

18 Now that need cannot be done from Washington. That has
19 to be done at the local level because that's where health care
20 is delivered, and I think that's why it's very important for
21 you -- us to be discussing what you can do in Alaska to be
22 able to make these things happen.

23 So I'm getting some noise here. I'm going to mute Nancy
24 Merriman's phone.

25 So what I'm going to talk about here is what I view as

1 the four functions that you have to have at the local,
2 regional, or state level to be able to make health care reform
3 work effectively. And I think the biggest challenge that most
4 people around the country are facing right now is simply lack
5 of information, lack of actionable information about
6 utilization and costs, particularly at the level of physician
7 practices. Physician practices don't know what's happening to
8 their patients outside the practice walls. They don't know
9 how often they're being hospitalized. They don't know if
10 they're going to the ER. And typically, if you talk to
11 physicians, they say I don't really even know what these
12 treatments and facilities and tests I'm referring people to
13 cost.

14 So I think a key strategy is to be able to get data to
15 help physicians --and I'm going to focus particularly on
16 physicians -- find opportunities for cost savings and quality
17 improvement and then be able to give them real-time
18 performance measurements to support quality improvement.
19 Having data that's a couple years old doesn't really help very
20 much, if you're trying to improve.

21 So how is Alaska doing? Well, it's actually very hard
22 for most places to find out how they're doing. We have fairly
23 limited data available. The only really systematically
24 comparable data around the country comes from Medicare because
25 Medicare is everywhere. And you find some interesting things

1 when you look at the Medicare data. So for example, if you
2 look at Medicare data -- and this is, again, old data. It's
3 2007. This is from the *Dartmouth Atlas*, but if you look at
4 the *Dartmouth Atlas* data, it sure looks like people in Alaska
5 have better hearts and worse joints than other states do
6 because you have rates of cardiac surgery, except for valve
7 replacement, that are on the order of 20% to 30% lower than
8 the U.S. average. But on the other hand, you're replacing
9 knees and hips at 5% to 10% higher. And apparently, people in
10 Alaska have really bad prostates, as you can see here, because
11 proctectomies are 20% higher than the national average. So at
12 surgery, you're high on some. You're low on other things.

13 As I mentioned, the big issue is chronic disease and so
14 are what are called ambulatory care sensitive conditions,
15 which are things like chronic disease admissions to the
16 hospital. Alaska is actually doing pretty well. You have a
17 much lower than the national average rate, which Medicare
18 beneficiaries (indiscernible - voice lowered) for ambulatory
19 care sensitive conditions, but there's still room to improve.
20 There are other states that have yet 20% lower than you do,
21 and there are people who do go to the hospital though. You
22 actually look like most places around the country. Those
23 chronic disease patients, if they are hospitalized, come back
24 to the hospital within one month at a very high rate. One out
25 of four congestive heart failure patients at Alaska hospitals

1 that are big enough to measure that are coming back.

2 Now these issues differ from region-to-region, and they
3 differ from condition-to-condition. There's a group called
4 Prometheus. The Health Care Center Institute came up with a
5 payment model for episode payments, but where there has been -
6 - actually, a lot of people are finding that (indiscernible -
7 voice lowered) useful around the country is to simply go in
8 and analyze data and help identify where there are
9 opportunities for improvement.

10 So what this chart that you're seeing shows is this is
11 for a commercial population in a different state looking at
12 how much is spent by condition. So across the bottom there is
13 congestive heart failure, chronic (indiscernible - voice
14 lowered) pulmonary disease, diabetes, et cetera, all the way
15 through hips and knees and pregnancy.

16 What they do is they divide the cost. The higher the bar
17 is how much that commercial payer is spending for patients in
18 each of those conditions, but what they do is they divide the
19 condition into two categories.

20 One is typical care, in other words, what you would
21 expect a patient to get in order to treat their diabetes, to
22 treat pneumonia, et cetera, but then PACs, potentially
23 avoidable complications, and their dark blue bars show things
24 for chronic disease patients, how often they are being
25 hospitalized, which is an avoidable complication, for the hips

1 and the knees, and it averages how often they have infections
2 and readmissions, and it gives you a picture of where the
3 opportunities are.

4 Now I probably could show you charts for several
5 different places. This chart looks different in different
6 places. So in some places, some things are high and other
7 things are low in terms of the potentially avoidable
8 complications, but the point is, without data, it is very
9 difficult to know in Alaska where the opportunities are for
10 quality improvement that will actually reduce costs, and you
11 don't want to flat-line with something like this.

12 So to me, the number one, by far, function that you need
13 to have available, if you're going to get successful health
14 care reform is to have data analysis, a quality and cost
15 analysis and reporting so that people know where the
16 opportunities are and can pursue them.

17 Now I want to make an important distinction here between
18 what I call measurement and analysis. A lot of people are
19 doing measurement today, and there has been a lot of focus
20 nationally on getting better measures that can be reported
21 publicly. The problem is that measurement today presumes that
22 we know what we're looking for and that we know what's
23 desirable and achievable and that we can legitimately rate and
24 rank divisions or hospitals based on the measures. That is a
25 very high standard, and it's not surprising that, because it's

1 a very high standard, we don't really have a lot of measures
2 that meet those criteria that are considered valid for public
3 reporting.

4 What I think we need a lot more of today is analysis,
5 exploratory analysis (indiscernible - voice lowered), the kind
6 of analysis I've just showed you from the Health Care Center
7 Institute folks that tries to say we know there are
8 opportunities out there, but we don't know exactly where they
9 are. We need to be digging through the data to see where
10 those opportunities are and how much progress we can actually
11 make in being able to achieve them.

12 That raises a question. If you do have the data, then
13 who should be accountable for achieving higher value care?
14 For a long time, we have, I think, acted as though it's health
15 plans that are somehow supposed to be accountable for doing
16 that or hospitals, but when you think about most of the kinds
17 of opportunities I've talked about -- keeping people well,
18 helping people with current disease manage their conditions --
19 physicians are at the core of that, and physicians -- even
20 though physicians and hospitals have to work jointly on things
21 like complications and infections, physicians also play a
22 major role in deciding which acute care provider patients go
23 to when there are choices in the community.

24 So in many ways, physicians, I think, are really at the
25 core of this notion of more accountable care, but that's going

1 to require very different kinds of skills and relationships
2 for physicians than they have been called on to have in the
3 past. They're going to need to develop or expand skills they
4 may already have in how to focus on reducing preventable
5 hospitalizations and how to reduce unnecessary testing.

6 Primary care physicians and specialists -- for many
7 patients, multiple specialists -- need to be working together
8 as teams to better manage complex cases, and physicians and
9 hospitals need to be working together on these quality
10 improvement cost and reduction efforts rather than being at
11 odds with each other.

12 And just to give you an illustration, I think, if you say
13 what kinds of skills do physicians or a physician practice
14 need to have if they're really going to be managing a patient
15 population and reducing the rate of inpatient episodes or
16 unnecessary testing, I'll give you my list of things.

17 I think, first of all, physicians, fundamentally, need to
18 have enough time to do good diagnosis, treatment planning, and
19 follow up, and we don't really give them that time, in many
20 cases, today.

21 Second is that they need some resources to help their
22 patients understand their conditions and how to manage those
23 conditions effectively. That isn't always -- that kind of
24 education isn't really cost-effective for physicians to do,
25 but they need to have resources, such as a nurse care manager,

1 available to help them do that.

2 Third, I think physicians need ways to be more proactive
3 about care. You can't really achieve these things, if you are
4 simply waiting for patients to come into the office with a
5 problem because, often times, they don't come into the office.
6 They end up in the ER. So having systems, like patient
7 registries, that enable physicians to be more proactive about
8 care and identify the patients who need to be contacted is
9 important.

10 Fourth is to start thinking about to better target
11 services because some patients need more of that proactive
12 attention and patient education than others do because they
13 are at higher risk of hospitalizations.

14 Fifth, as I mentioned, coordinate relationships with
15 other specialists and hospitals.

16 In some ways, sixth and most fundamentally, is data and
17 analytics to help them understand how they're doing, where the
18 problems arise, so that they can end up focusing efforts on
19 trying to improve those things.

20 Now interestingly enough, if you think about, all these
21 capabilities exist today in every community in the country,
22 but most of those capabilities we have invested in health
23 plans or disease management vendors, many of which are trying
24 to do these things with patients, but completely independently
25 of the patient's own physician and that doesn't work very

1 well, and the research that's been done on this shows that
2 that doesn't work very well.

3 Medical home projects have been working to try to build
4 those capabilities, give investors more time, (indiscernible -
5 voice lowered) education, support, being proactive, but they
6 really don't go far enough up that list of capabilities to be
7 able to get at some of these true population management cost
8 reduction skills. And I think we're going to need,
9 particularly, to find ways to help physician practices think
10 about how to calculate the return on investment. So if you're
11 going to hire a nurse to do patient education, how much of a
12 result do they have to have in terms of reducing ER visits and
13 hospital inpatients to pay for that additional cost? When is
14 the timeframe for the return on investment going to be coming?

15 We've been doing a lot of long-term initiatives in terms
16 of prevention and diabetes management, but we need to be
17 focusing on things that are going to give us some short-term
18 savings because people are looking for savings right now, and
19 then how to better target their patient services.

20 So I think a key goal is to be able to give physicians,
21 and particularly physician practices, the capacity to deliver
22 this kind of more accountable care. It doesn't necessarily
23 mean the individual doctors have to be doing this, their
24 practice has to be doing it. They may be looking to other
25 partners. Health plans might well be the right partners to do

1 this, but it's really about starting with physicians
2 developing these kinds of capabilities.

3 So number two, for me, on this list of what communities
4 need to be doing is redesigning the way they deliver care to
5 come up with more value-driven delivery systems that achieve
6 better quality outcomes and higher efficiency.

7 Now these two things interact because you can't manage
8 what you can't measure. It's very hard to be more effective,
9 if you don't know how you're doing. And other communities are
10 looking at how to do this.

11 For example, in Maine, this is just an example of
12 dashboards that Maine is making available to physician
13 practices so they can understand how they compare to other
14 practices, how their patients are doing, where there may be
15 overutilization for their patients. These are not things that
16 appear on a public website, in many cases. A lot of them are
17 just things that are information being provided to physicians,
18 but then it gives the opportunity for the physician to
19 identify ways that they can change.

20 So even if you said we have data, physicians are ready to
21 do this, that's when you run smack into the problem of the way
22 we pay for health care today because physicians and hospitals
23 today lose money if you reduce complications, and infections,
24 and readmissions. Physicians and hospitals lose money if they
25 keep patients out of the hospital, and nobody in health care

1 makes any money today when patients stay well. So the payment
2 system is not exactly oriented in a way that effectively
3 supports these kinds of quality improvements and cost
4 reduction efforts.

5 So to me, number three in this four-part equation about
6 what communities need to put in place is better payment
7 systems.

8 So there are really two fundamental concepts in payment
9 reform. One is the notion of an episode payment. The idea of
10 an episode payment is to say, when somebody has an acute care
11 episode, they have a heart attack, they have a broken hip,
12 whatever, that there should be a single payment for that with
13 no extra payment for complications and infections and
14 readmissions that are related to that treatment. It's the
15 exact same concept that every other industry in America has of
16 giving a warranty on their care, so that you don't charge more
17 when problems arise.

18 Now that notion of a warranty in health care sounded like
19 an insane idea up until a few years ago when the Geisinger
20 Health System of Pennsylvania started to do this. They don't
21 call it a warranty -- the *New York Times* calls it a warranty -
22 - but what they do is, essentially, they do that. They are
23 offering certain care for a single price, everything
24 preadmission, both physician and hospital services, post-acute
25 care, and importantly, anything for related complications for

1 readmissions. And they started this with cardiac bypass
2 surgery, and they have been systematically expanding this to
3 other categories of treatment, including things like maternity
4 care and back pain that don't get initiated by a hospital
5 stay, but actually involve a lot of outside the hospital care.
6 And what they found was that the different payment structure
7 enabled them to completely reinvent the way they delivered
8 care and achieved, in very short order -- these are their 18-
9 month results for cardiac bypass surgery -- not very small
10 little quality improvements, but 20%, 40%, 60% improvements in
11 reductions in infections and complications and readmissions at
12 an institution that was already viewed as a high
13 quality/quality leader nationally in terms of the work that
14 they did.

15 Now the myth that developed about this kind of approach
16 is that you have to be a Geisinger health system, a big
17 integrated health delivery system, to do something like offer
18 care with a warranty. But the fact is that the earliest
19 documented example of anybody doing or offering a warranty in
20 health care was a single doctor in Lansing, Michigan, an
21 orthopedic surgeon, a shoulder and knee guy who said I'm going
22 to give a two-year warranty. Anything goes wrong that needs
23 to be done, we're going to do it at no extra charge, and it's
24 in the literature. The insurance company paid less. The
25 surgeon made more money. The hospital made more money. And

1 how does that kind of miracle occur? It's because they
2 actually were able to reinvent the way they deliver care,
3 reduce all of the unnecessary services, and then actually make
4 care for the patient better, reducing complications and
5 readmissions. So this can be done by individual physicians as
6 well as a big health system.

7 Now what people fear is that, somehow, this can't work.
8 This is a really a challenge that's going to reduce revenues
9 for people. And I want to show you why this actually can be a
10 win-win-win all around.

11 So I'll take a hypothetical example here of some \$10,000
12 procedure that a health plan or Medicare is paying \$10,000 for
13 today, but let's assume that 5% of the time, the patient gets
14 an infection, and when the patient does, a serious infection
15 costs \$20,000 to treat that infection. So on average, the
16 health plan or Medicare isn't really paying \$10,000; they're
17 paying \$11,000 -- excuse me -- on average for these
18 procedures.

19 Now let's suppose that you were a health provider and you
20 wanted to offer this procedure with a warranty where you would
21 say I'm not going to charge any more for infections whenever
22 they occur. How much would you charge for this procedure, if
23 you were going to give a warranty?

24 Well, the answer is you would charge \$11,000 because, if
25 you charged \$11,000 but you didn't charge any more for the

1 infections when they occurred, you would be getting exactly
2 the same amount of revenue that you're getting today. So of
3 course, you say well then, what do I accomplish by that?
4 Well, it's because you actually have now changed all of the
5 incentives because this hospital health system, if it can
6 reduce the rate of infections from 5% to 4%, it's actually
7 reducing its costs because it no longer has to treat this many
8 infections for the patients, but it's not losing its revenue
9 because it's still charging \$11,000 for a procedure. So it
10 actually is better off financially. It's operating margins
11 will improve. But we want to save a little bit of money in
12 health care, right, so this provider can now say I can offer
13 this procedure for \$10,800, and maybe the health plan will
14 send me some more patients because I am now the higher quality
15 with lower infection rate and lower cost provider with a lower
16 price or cost for a procedure. And this incentive continues
17 because, if they can find ways to drive the rate of infections
18 down even further, they reduce their costs and they improve
19 their margins. And the closer you get to zero, you end up
20 with the patients are better off because they're getting fewer
21 infections. The cost to the payer is lower, and the provider
22 is more profitable. So it's a win-win-win all around.

23 Now this is different than what Medicare and a lot of
24 health plans have been doing. What they've been saying is I'm
25 simply not going to pay for infections. Now what that does to

1 a hospital or health system is it basically puts them into a
2 loss situation the beginning. Before they even figure out how
3 to get the infection rate down, you're forcing them to lose
4 money, and if they can ultimately get rid of all of the
5 infections, that ends up exactly where they started, with the
6 same margins they had before, but they lose money all along
7 the way.

8 So the warranty approach actually can help the provider
9 basically align the quality incentive and the financial
10 incentive, so that doing better in terms of quality actually
11 also means doing better financially.

12 So episodes have a lot of advantages to them. They have
13 one major weakness. The major weakness of the episode payment
14 is that it doesn't do anything to prevent unnecessary episodes
15 of care. So if you're managing a chronic disease population,
16 for example, the idea is not simply that, every time they go
17 to the hospital, you have an efficient, successful outcome,
18 but you reduce the frequency with which they go to the
19 hospital and you reduce the overuse of things like cardiac
20 surgery and back surgery that are occurring in some
21 communities.

22 So that leads to the second big idea in health care
23 payment reform, which is what I like to call comprehensive
24 care plan. The idea is a single payment for a patient's
25 condition or set of conditions, to manage that, regardless of

1 what's necessary, how many times they have to go to the
2 hospital or what happens whenever they're in the hospital. A
3 lot of people call this global payment. I don't particularly
4 like the term global payment because I'm afraid the patients
5 are going to think that we're telling them we're going to send
6 them to (indiscernible - voice lowered) India to be able to
7 able to get their care. The idea, really, is that this is a
8 single payment to provide comprehensive care for a patient's
9 conditions.

10 We know that, again based on many projects here in this
11 country and other places around the world, that you can get
12 very significant reductions in hospital admissions and ER
13 visits, again not a few percentage points, but 20%, 40%, 60%
14 reductions, through very simple changes by using patient
15 education and self-management support, by using telemonitoring
16 and things like that.

17 The problem is, today, we don't pay for those things.
18 What we pay for is patients to go to the physician's office.
19 We don't pay for the physician to talk to the patient on the
20 phone if the patient calls up and says they're having a
21 problem. We don't pay for the physician practice to have a
22 nurse work with the patient to be able to help them manage
23 their condition, but we pay every time the patient shows up in
24 the ER or gets a test or has to be hospitalized.

25 So the idea of a comprehensive care payment or global

1 payment is to say there is going to be a single payment for
2 that patient's condition, and if a physician practice or
3 Accountable Care Organization or whatever you want to call it
4 thinks that it would be desirable to have (indiscernible -
5 voice lowered) for patients or to hire a nurse care manager or
6 to do telemonitoring, they have the flexibility, under the
7 payment, to be able to do that, but they have to be
8 accountable for whether that's helping people stay out of the
9 ER or out of the hospital.

10 Now people who have been depending on health care for
11 very long immediately say wait; this is capitation, right?
12 And we don't like capitation. Nope. This is different. It's
13 different in some very important ways.

14 Traditional capitation systems basically pay a single
15 amount per patient, regardless of what the patient's
16 conditions were. So if you ended up -- if you were a
17 physician practice or a health system under capitation and
18 you've got sicker patients coming in your doors, you didn't
19 get any more money, even though we know that sicker patients
20 need more health care services. So the idea of a
21 comprehensive care payment is to adjust the payment based on
22 the severity of the patient's condition, a risk-adjusted
23 payment.

24 The second problem with traditional capitation systems
25 was that, if you got that unusually expensive case, the

1 million dollar cancer case, sorry, no more money to be able to
2 cover that. You've got to pay for that out of your capitation
3 payment, and particularly, small physician practices could go
4 bankrupt with something like that, and a lot of them did in
5 the 1990s because of exactly that reason. So the idea of
6 comprehensive care payment is to put limits on the total
7 amount of risk that providers will accept for these
8 unpredictable events.

9 The third problem with traditional capitation is that the
10 providers got paid, regardless of the quality of care that
11 they delivered, and patients knew that. So the idea of
12 comprehensive care payment is to have some bonuses or
13 penalties built in, based on the actual quality of care.

14 But there are two very good things about capitation type
15 systems that physicians who practice under them like. First
16 of all, it's the only payment system that actually rewards you
17 for keeping your patients well because you still get paid,
18 even if the patient doesn't need any health care services.
19 That's a good thing. We want to actually encourage keeping
20 patients well.

21 The other thing that's really good about capitation
22 systems is they're the less flexible payment system. So the
23 doctor or hospital or (indiscernible - voice lowered) is not
24 really constrained by what Medicare or the health plan says
25 that they will pay for or won't pay for, how much they'll pay

1 for it. They have the flexibility to design care in a way
2 that works the best for the patient. So that's what we want
3 to be able to get to with these comprehensive care payment
4 systems is something that solves the problem of traditional
5 capitation systems, while keeping its strengths.

6 This is what Blue Cross Blue Shield of Massachusetts has
7 been doing through what they call their alternative quality
8 contract. It's a single payment to a provider or organization
9 for all of the cost of care associated with a population of
10 patients, but it's get adjusted up or down annually based on
11 how sick those patients are, and there is a bonus paid for
12 delivering higher quality care.

13 But also in addition to that, a very important feature of
14 this is it's a five-year contract. So there is the
15 opportunity for people to make investments in (indiscernible -
16 recording interference) and in infrastructure, et cetera, that
17 enables them to be able to reap the benefits of that because
18 they have a long enough period to be able to do it. And
19 they've had very broad participation in this, including with
20 organizations as small as a primary care IPA with 72
21 physicians, and they've very positive results from this, both
22 in terms of quality and cost control.

23 Now the problem with the comprehensive care payment
24 notion is that it's a big jump from fee-for-service to
25 comprehensive care payment, and for a lot of small physician

1 practices, that's a real challenge, rural areas, et cetera.
2 So we need to have transitional models.

3 Now what you see nationally from both Medicare and from
4 the number of health plans is the notion of shared savings,
5 and shared savings get promoted as being a transitional model
6 that makes it easier for providers to move into this space.
7 But the problem with shared savings is what it's basically
8 saying is, if you can somehow figure out how to reduce those
9 ER visits and hospital stays, we'll give you some of the
10 savings back in a couple years maybe, but there's no up front
11 change in either money or the way care is being paid for to
12 enable the care to be redesigned. And as a result, I think
13 it's very problematic.

14 I am not a fan of the shared savings model because,
15 particularly thinking about primary care practices, it doesn't
16 do anything to give them the up front money that they need to
17 hire the nurse care managers, to put in better Information
18 Technology, et cetera, and any additional money they get comes
19 years after the care changes are made. It requires -- total
20 costs could go down for the physician practice to receive any
21 increase in payment. So you improve the care for your chronic
22 disease patients, but you end up with more people getting knee
23 surgery, and sorry, no savings for you.

24 I think the folks in places like Miami, that are pretty
25 high utilizers might like this better than places that have

1 lower utilization. And fundamentally, it doesn't actually
2 change anything about the fee-for-service system. It's
3 basically a new form of pay-for-performance added on top of
4 the existing broken structure. So it is not really true
5 payment reform. So I think there are better ways.

6 A better way is to simulate both the flexibility and the
7 incentives of global payment or comprehensive care payment
8 without necessarily jumping the whole way. How would you do
9 that?

10 Well, you could provide an up front care management
11 payment to a physician practice or health system, similar to
12 what many medical home physicians do now, so that there are
13 more resources available for patient care, but you need to
14 have some specific accountability associated with that in
15 terms of making sure that those resources are directed in a
16 way that reduces ER visits and hospital stays. And so a way
17 to do that is to have some pay-for-performance type bonuses
18 for penalties attached to that utilization rate, but then
19 provide some feedback to the physician practice in terms of
20 upside or downside.

21 Let me give you an example of how this concept works. So
22 let's take a hypothetical underpaid primary care practice,
23 four doctors, 2,000 patients per physician. The revenue that
24 they're getting from health plans amount to \$1.1 million a
25 year. They have money that goes to overhead to pay for the

1 staff and billing systems and everything else, and the
2 physicians are left with \$180,000 salary. At the same time,
3 the patients are going to the ER at a rate of 200 per 1,000.
4 It's a typical commercial ER utilization rate around the
5 country. And about 40% of those ER visits are preventable in
6 the sense that they are everything from sniffles to the
7 chronic disease admissions that could have been prevented, and
8 the health plan is spending about \$1,000 per visit. So the
9 health plan is spending \$640,000 a year for ER visits for this
10 practice's patients.

11 Now what if the primary care practice said you know, if
12 we invested some more resources, say we hired a nurse
13 practitioner who could do more patient education, who could
14 answer the phone when patients call with problems, et cetera,
15 we think we could actually reduce those preventable ER visits
16 by 40% of the 40% and that's been done in a number of medical
17 home initiatives around the country. We could save the payer
18 a quarter-million dollars, but look at the equation here. The
19 primary care practice has to lose, basically, \$90,000 in order
20 to save the health plan a quarter-million dollars. So the
21 obvious solution is to say well, the health plan should pay
22 for the \$90,000 because, if they pay for that, even after
23 paying the \$90,000, they're still netting \$166,000 savings.
24 The health plan's concern is well, how do I know, if I give
25 that \$90,000 to the practice, that they're actually going to

1 focus on reducing ER visits?

2 So that's where the upside and downside incentive comes
3 in. The health plan might say to the practice, I'll share
4 with you 50% of the net savings. So even if I give you back
5 half of that \$166,000 net savings over on the right side of
6 the chart here, that still leaves the health plan with \$83,000
7 net, which is a 13% savings (indiscernible - voice lowered)
8 what they were paying in terms of ER visits. That \$83,000
9 could represent a 12% increase in physician salaries in that
10 primary care practices. So you end up with a win-win-win.
11 The patients aren't going to the ER as often anymore. The
12 doctors are making more money, and the payer is actually
13 saving money. But the only way it works is to give the
14 provider, the physician practice or health system up front
15 money to be able to make those investments, and they have to
16 have targets that are things that they can actually influence,
17 like things like preventable ER visits.

18 This is what your neighbors to the south have just put in
19 place this spring on a pilot basis with seven health plans and
20 Medicaid plans participating in this. So it's a big, very
21 complicated, multi-payer initiative, but basically, it starts
22 out looking like a typical medical home program that pays some
23 up front money to primary care practices. Very flexible.
24 They can do whatever they want with it, but the practice
25 agrees to specific targets for reducing non-urgent ER visits

1 and ambulatory care sensitive hospital admissions by amounts
2 which will generate savings for the health plans at least
3 equal to this up front care management payment. If the
4 primary care practices beat the target, they actually get a
5 bonus. They get a shared savings payment. But if they don't
6 meet the target, they have to pay some of that up front money
7 back and that's actually something that the primary care
8 practices said they wanted. They couldn't operate with just a
9 shared savings payment. They didn't want to have health plans
10 dictating to them how they should improve their care, but that
11 they wanted -- they were willing to take greater
12 accountability for getting more resources and more flexible
13 resources up front.

14 And if you think about this, I mean, everybody has been
15 waiting for Medicare to do things, but at the state and
16 regional levels, that's actually where all the innovations
17 have been occurring. I mean, if you think about it, almost
18 every place in the country has some kind of pay-for-
19 performance system. Now Medicare has only just put its first
20 system in place this year. There are medical home initiatives
21 all over the country. Medicare's only initiative is really
22 actually piggybacking on eight state medical home programs.
23 There were episode payments long before Medicare's newly-
24 announced program this week and also total cost accountability
25 models. So lots of things are happening, and I don't think

1 anybody should think that they have to wait for the Feds to do
2 something to actually do something at the local level. But
3 better payment systems require good quality measurement
4 because the concern is that, if you're giving health care
5 providers more accountability for costs, how do we know that
6 they're not going to skimp on care or ration care?

7 So you have to have ways of measuring health care quality
8 and building incentives around that into it. But I think a
9 key question that needs to be faced is, where did that get
10 done? At the federal level? I think it's best done at the
11 community level, and we have, in a growing number of
12 communities around the country, local initiatives to be able
13 to measure quality with the participation of the physicians
14 and hospitals to make sure that the quality measures make
15 sense, the data makes sense, and figure out where they should
16 be focusing their efforts.

17 So back to my four-part chart. That ability to do data
18 analysis and reporting supports the payment system revisions
19 that we're talking about, and the key other reason why the
20 data is critical is something that almost nobody ever talks
21 about. It's not just the payment method that we need to be
22 able to make sure is right. We need to get the right price
23 because, even with the incentives going in the right
24 direction, if the payment level is too high, you don't get any
25 savings and you don't really have any incentive to transform

1 care. If the payment level is too low, then your health care
2 providers end -- they're not able to deliver high quality care
3 because they don't get enough money for it. Medicare just
4 dictates prices, but this is all negotiated between private
5 payers and providers.

6 And so if you think about these concepts, if you're
7 moving from fee-for-service to episodes or global payments,
8 the health care provider needs to know what his current
9 utilization rates are and complication rates, et cetera, in
10 order to know whether an episode or a global payment amount is
11 adequate, and the purchaser -- the health plan, the state,
12 whomever is buying the care -- also needs to know that same
13 information in order to know whether they're getting a good
14 deal at that price compared to what they have today. And both
15 sets of data have to match because you don't want to have the
16 providers and the payers arguing over the data.

17 Now I'm going to jump off the presentation that most of
18 you have. So those of you are looking won't be able to see
19 just a couple slides, but I thought I would -- given your
20 discussion yesterday about pricing information, I wanted to
21 show you why this really requires some fairly sophisticated
22 data analysis.

23 Today if you would look simple prices that providers are
24 being paid, it's hard to know whether somebody who is offering
25 a lower price is actually giving a better value. So in my

1 little hypothetical example here, I have provider number one
2 who is charging \$10,000 and being paid \$10,000 for a
3 procedure. Provider number two is being paid \$9,500, and you
4 say well, provider number two is better. They're 5% or less.
5 Or maybe a different state is being paid less. And you say
6 well, does that mean Alaska is too expensive? The problem is
7 that you have to know what else is going on.

8 So just to take my infections example again, let's
9 suppose here that provider number one, which looks like it's
10 the more expensive provider, has a 5% infection rate and
11 provider two though has 10% infection rate. Well, what
12 happens, if you really think about the total cost of the care,
13 provider number one is actually the more -- the lower cost
14 provider because, when you add in all those infections and
15 complications and readmissions, the amount they are being paid
16 per procedure is lower, even though they look like they're
17 being paid more on the surface.

18 Now when you move to the warranty notion, episode
19 payment, if there was a third provider who came in and said I
20 want to offer this procedure with a warranty, they would
21 actually have to charge more than what the other two providers
22 are offering, but you would actually be spending less at that
23 provider than either of the other two.

24 So you can't just be looking at price. You have to look
25 comprehensively at all of these issues and that's why you have

1 to have good data that everybody trusts to be able to figure
2 out how to price these things.

3 This doesn't happen overnight. You have to have -- you
4 can't just put the payment systems in place and somehow
5 imagine that, all of a sudden, doctors and hospitals are going
6 to be prepared to use them. They have to co-evolve.

7 I mentioned earlier the kinds of skills and capabilities
8 that physician practices are going to need to be able to
9 manage better patient care. What I didn't talk about is --
10 and I guess I should say there are, in fact, examples around
11 the country of even small physician practices that are doing
12 this. People think you have to have very large groups or
13 health systems doing this. There are examples in many states
14 of small primary care practices and small PPT and specialist
15 practices that are working together through IPAs to do this.

16 But what I haven't talked about is, what does this mean
17 for hospitals? How are hospitals going to have to change?
18 Well, you don't have to think very hard to look at the charts
19 I've shown you to realize that, if we actually are focusing on
20 keeping people well, keeping those chronic disease patients
21 out of the hospital, and reducing infections and complications
22 and readmissions, for hospitals, that means fewer patients,
23 fewer admissions, less revenue per admission. So what's this
24 mean in terms of how will hospitals have to change?

25 Well, my answer to that is that they may well be smaller

1 but higher priced. Now you might say higher priced, boy, that
2 sounds a little counterintuitive here. We're trying to reduce
3 health care spending, aren't we? But if you think about this,
4 in any other industry, what is success? Success is that a
5 business sells more product. As a business sells more
6 product, it can spread its fixed costs across more of that
7 product, and it can actually then sell its product at a
8 cheaper price. So that's success. Sell more products, sell
9 cheaper, and you get a virtuous cycle. And I don't care. We
10 don't want to sell more product. We actually want to figure
11 out how to sell less product. We want to keep people well.
12 But hospitals, particularly, most of their costs are fixed
13 costs. So it's not that somehow economics is different in
14 health care. It's exactly the same. It just goes in the
15 opposite direction. If we end up having hospitals with lower
16 volume, they are likely going to have higher unit costs, but
17 we have to do it in a way to ensure the total spending is
18 going to be lower.

19 Just to give an illustration of this, this is just sort
20 of a hypothetical chart that says, what if a hospital had a
21 20% reduction in its admissions, its volume? You might well
22 find, as a result of that, that the costs at the hospital only
23 went down by 7% because the hospital ends up having a lot of
24 fixed costs it still has to cover. But the payer, the health
25 plans and Medicare, will happily pay 20% less for 20% fewer

1 patients in the hospital. So what's that mean to hospitals?
2 Again, you don't have to think very hard to realize, with a
3 20% reduction in revenue and 7% reduction in costs, the
4 hospital is going to lose money. But it also means that, if
5 the health plans were paying the right amount for care at the
6 beginning, they're no longer paying the right amount. They're
7 actually underpaying for care for this higher quality care
8 that they're getting right now. So there is going to need to
9 be some repricing. And there's still an opportunity. Payers
10 can still save money without -- but they can do it without
11 causing negative margins for the hospitals.

12 So I think that a lot of communities are going to need to
13 be thinking about, what's the glide path to the future for the
14 hospitals? Now if your hospital is bulging at the seams and
15 you're trying to figure out where to put patients, you may be
16 happy to have fewer of these chronic disease admissions and
17 readmissions, but for a lot of small community hospitals,
18 that's who the majority of their patients are, and the
19 reductions that we're talking about trying to encourage in
20 chronic disease admissions and readmissions could cause them
21 very serious financial problems.

22 The Geisinger Health System of Pennsylvania has been so
23 successful with their medical home initiatives that they have
24 actually seen their admissions to community hospitals go down
25 by 50%, 5-0 percent.

1 So in the long run, hospitals can restructure, but if
2 you're the only hospital in the community, you're still got to
3 have that hospital. So you've got to figure out how to pay
4 that hospital in a way that will maintain those critical
5 services for the community, and to do that, you have to have a
6 much better understanding of hospital costs than most people
7 do today.

8 Now even if you do this, if you get one payer, Medicare
9 or a commercial plan, who says I'm willing to do this, it's
10 still very challenging, if not impossible, for the doctor or
11 the hospital to change because, do you say I'm going to
12 prevent infections for this payer of patients, but not for the
13 others? Doctors and hospitals treat all their patients the
14 same.

15 So if you're going to reinvent care, you have to do it in
16 a way where the incentives are aligned. So it's going to be
17 very important in the future to have the payers all changing.
18 I'm not worried that I think most health plans are going to be
19 changing their payment systems. I think the risk is that
20 they're all going to change them in different ways, and even
21 if they're all better than they were before, if they're all
22 different, you're going to end up in a situation where the
23 doctors and the hospitals are going to have great difficulty.
24 They're going to spend more time managing the payment systems
25 than they are improving the way the deliver care.

1 And we're starting to see some better care coordination
2 occurring around the country. In a number of states, a lot of
3 hard effort to try to get multiple payers participating in
4 this. You typically have to have a facilitator. Either state
5 (indiscernible - recording interference) government can do it,
6 which has an anti-trust exemption capability, but there have
7 also been cases where non-profit regional health improvement
8 health collaboratives have brought everybody together to agree
9 on what they want to do.

10 The biggest missing piece in all of this has tended to be
11 Medicare, and I think their initiatives, including the one
12 announced this week, really provide an opportunity for
13 Medicare to participate in ways that we didn't have before.

14 Now as far as the payment changes, we also have to be
15 thinking about benefit changes because payment is just about
16 the health care providers, giving them the ability and the
17 incentives to keep their patients well, to avoid unnecessary
18 services, to be more efficient, to coordinate. It takes two
19 to tango in health care. You've got to have the patients
20 engaged. They've got to have the ability and the incentives
21 to improve their health, take their meds, to allow somebody to
22 coordinate their care, and to pick the highest value providers
23 and services, and today, the benefit structures that we have
24 in most health plans in Medicare don't do that.

25 One, I think, major example of this is that we have an

1 almost complete disconnect in this country today between
2 pharmacy benefits and medical benefits, and for all those
3 chronic disease patients that I was talking about, one of the
4 things that helps them stay out of the hospital is taking
5 their chronic disease maintenance medications. But if they
6 have high co-pays, if they're in the Medicare donut hole,
7 what's the doctor supposed to do to be able to solve that
8 problem? And if those patients end up in the hospital because
9 they can't afford their medications, that's clearly an
10 opportunity to fix things.

11 We also have to be thinking about, how do patients choose
12 the highest value provider? And if you think about it, if I'm
13 going to get my knee replaced today and there are three places
14 I could do it and they all have three different prices, which
15 one do I pick? Well, most benefit structures today use co-
16 pays or co-insurance or high deductibles, and if you think
17 about it, none of those actually give me the incentive to use
18 the lower cost provider. If I have \$1,000 co-payment on my
19 surgery and I look and I say wow, that provider number three
20 there, \$33,000, they must be doing something better that
21 they're charging so much more. I think I'll go get my knee
22 done there. What a number of employers around the country are
23 looking is to say let's figure out who the lowest cost,
24 highest quality provider is and say we will pay that amount,
25 in this case, \$23,000, and if the patient wants to go

1 someplace else, they may have to pay all or a portion of the
2 difference to be able to do that.

3 The benefits and the payment are parts of health plans,
4 but which health plan gets used and what the benefit structure
5 is, particularly, is up to the purchasers in the community,
6 the (indiscernible - voice lowered) employers, state
7 employees, et cetera, really determine that, and the purchaser
8 are often reticent to make benefit changes, if they don't
9 think that their employees are going to be supportive of that,
10 which goes back to the very beginning, why I think we need to
11 be talking about this is all better for the patients.

12 So if you've been wondering all along what's the fourth
13 box in the four-box chart, to me, it's consumer support, which
14 I think is fundamental to all of this, not only directly in
15 terms of education engagement, but making sure that we are --
16 when we're talking about measuring, we're measuring consumer
17 experience and that we have the patients actively engaged in
18 the way care is being designed to be able to make it work for
19 them.

20 Now I (indiscernible - voice lowered) -- if you think
21 about this, this is complex. It's not like, somehow, we can
22 just change the payment system and everything magically
23 adjusts. All these different things have to be done, lots of
24 specific tasks under each of them, and they all have to be
25 done in coordinated way. You can't change the payment system,

1 if the providers aren't changing the way they deliver care.
2 They can't change the way they deliver care, if you don't
3 change the payment system. And the question is, well, who is
4 going to coordinate and connect all that?

5 I'm going to (indiscernible - voice lowered) for the
6 federal government doing that, but I don't think that's
7 anything that the federal government is going to be able to
8 do. That's what a growing number of communities around the
9 country are trying to through what we call regional health
10 improvement collaboratives. They're non-profit entities.
11 They don't deliver care. They don't pay for care. What they
12 do do is they bring all of the health care stakeholders in the
13 community to a round table and provide some of those critical
14 functions, like data analysis, together and quality
15 improvement and technical assistance to be able to help people
16 make the transition together, and there are a growing number
17 of these around the country. These are the ones that are the
18 members of the Network for Regional Health Care Improvement.
19 But I think those kinds of capabilities in the community that
20 enable everybody to coordinate are going to be increasingly
21 important.

22 So my concluding message is, don't wait for Washington.
23 I don't think that there is any one-size-fits-all solution or
24 implementation path to this. I think every community and
25 state is going to be different, and the best the federal

1 government can do is to support the local strategies. I do
2 think it's critical to educate all the stakeholders in the
3 community and to build consensus on the need for this and then
4 bring everybody together to design what, I think, can be win-
5 win-win approaches for the local community and a transition
6 strategy for getting there, and then get the relevant federal
7 and state support for those strategies, and then measure how
8 you're doing, and I think there will, inevitably, be --
9 problem arise and challenges, and you don't want people to go
10 back into their own corners and blame somebody else. You want
11 to have a mechanism where all of those stakeholders can come
12 together to be able to make it work.

13 So that's my (indiscernible - voice lowered) tour of
14 payment and delivery reform, et cetera, and with that, I would
15 be happy to take any questions, challenges, disagreements that
16 you may have. And hopefully, there is somebody still out
17 there in Alaska.

18 CHAIR HURLBURT: We're still here. Thank you very much.
19 That was excellent. That was very helpful, and I don't think
20 I've ever seen anybody go through 106 slides so well and cover
21 all of them so well. So we very much appreciate that.

22 MR. MILLER: Thank you.

23 CHAIR HURLBURT: We have about 25 minutes left before our
24 Reactor Panel, so this will be for members of the Commission
25 here for any questions you have or comments, and I want to

1 start with Noah. You might -- maybe if you could just
2 introduce yourself and say who you represent or what you do,
3 it would be helpful.

4 COMMISSIONER LAUFER: Hi, I'm Noah Laufer, a primary care
5 doc here in Anchorage. I'm a member and president of a group
6 of 13 docs. We've been here a long time. And I agree with a
7 lot of the things you said. There were quite a few times
8 that, you know, I bristled, as you probably imagined.

9 The first thing that comes to mind is this whole idea of
10 who should be at the center of the risk, and you know, for
11 bizarre historical reasons, employers, largely, bear the
12 burden of health care costs. They don't like the risk, so
13 they pay the health plan to take the risk. The health plan
14 doesn't like the risk, so they have the hospital take the risk
15 or the medical community. The medical community doesn't like
16 the risk, so they think the family doctor should take the
17 risk. I'm thinking -- I'm trying to influence or manipulate
18 somebody to change the behavior, and I get a couple 20-minute
19 sessions a year. I'm not there when they eat the donuts and
20 smoke the cigarettes and drink too much alcohol, and it's
21 really, ultimately, the patients' responsibility. And you
22 know, I do need the tools to do that. So obviously, it all
23 flows back to the patient and that leads to another idea.

24 The problem with the system is that it's too bloated and
25 byzantine. To me, the fundamental unit is the relationship

1 between the patient and physician, and if I'm going to take
2 the risk as a primary care doctor, a lot of the other entities
3 don't have a reason to exist. If I'm actually the insurer,
4 then I'd like to collect the money. If the system works
5 right, the hospitals aren't just smaller and more expensive.
6 They are less relevant and more like community hospitals used
7 to be. The whole industry of pharmacy benefits management
8 goes away. The imaging benefits management goes away, a lot
9 of these entities that don't need to exist. And if we're
10 trying to take an existing system and make it work better, it
11 needs to be leaner. We're obese.

12 The final thought is one of these slides -- I think it
13 was called Prometheus. If you look at the entities on the
14 left where we're doing bad, almost all of those are
15 socioeconomic-influenced diseases and they're all related to
16 obesity, for Dr. Hurlburt. Thanks.

17 MR. MILLER: I didn't hear the last point that you were
18 making. You sort of faded out there when you were talking
19 about Prometheus and socioeconomic something.

20 COMMISSIONER LAUFER: On the slide that relates to -- I
21 think -- was it called Prometheus? It's a blue bar graph.
22 Yeah (affirmative). It says, "Example of Prometheus Analysis
23 of Avoidable Complications." These were for readmissions.
24 The left hand side of this that has CHF, COPD, diabetes,
25 asthma, hypertension, coronary artery disease, and

1 gastroesophageal reflux disease, these are related to smoking
2 and obesity, every one of them and that's why they're harder
3 to take care of. That's why there are more readmissions
4 because -- you know, I've never told someone they should quit
5 smoking and they say oh, really, I didn't know that, or they
6 should lose weight. Those are hard things to tackle, which
7 actually leads to another issue.

8 If you want to show good data and say that I offer value,
9 say, doing a hip replacement, the simplest thing is to only
10 operate on healthy people or even do it a little early, when
11 they're still, you know, young. To deny.....

12 MR. MILLER: Let me -- let me.....

13 COMMISSIONER LAUFER: Yeah (affirmative).

14 MR. MILLER: Let me make a couple comments. First of
15 all, that chart provided there, that Prometheus chart, that is
16 a commercial population. So those are all, you know, employed
17 people, a working population.

18 And one of the interesting things about that chart is a
19 lot of commercial insurers think that they don't really have a
20 problem with congestive heart failure and COPD, that that's an
21 elderly or low income problem, but what the data says is, even
22 though you spend less on those categories in total than you do
23 on diabetes, the potential savings is higher.

24 What I would say to your first point is a critical
25 (indiscernible - voice lowered) issue in all of this is to be

1 able to divide what we call insurance risk from performance
2 risk, and the idea is that there are things that physicians
3 can control. There are things that hospitals can control.
4 There are things that they can't. They don't really control,
5 fundamentally, you know, whether somebody gets cancer. What
6 they can control is how effectively a patient's condition is
7 treated. And what you want to do in terms of risk is you want
8 to be able to divide up the risk appropriately, so that
9 physicians are taking responsibility for performance of things
10 that they can control and insurance companies are taking
11 responsibility for the things that they can't control because
12 that's really what insurance is fundamentally about is the
13 risk of whether you get sick or not. And what we've had in
14 the past is we've gone to one extreme or the other. We either
15 have insurance companies taking all the risk, including the
16 performance risk, which then means that they have to put in
17 systems to try to watch over doctors to make sure that they're
18 doing things the way the health plan thinks is the right way
19 to do it. Or we've had systems, like traditional capitation
20 systems, which try to give all the risk over to the
21 physicians. And what the payment model does in what we're
22 talking about here -- the idea is to divide up the risk
23 appropriately, so that health plans provide insurance against
24 health problems and health care providers take responsibility
25 for how effectively those health problems are addressed.

1 Now I would say that there are a number of cases around
2 the country where physician groups and IPAs and health systems
3 that are good at measuring -- good at managing performance
4 risk include -- they could take on insurance risk, too. They
5 could assert their own house plan and be able to offer that.
6 That's sort of where health plans started in the first place
7 as basically prepaid health care. But I don't think that you
8 need to do that, but I do think that the key thing is being
9 able to recognize that it's not transferring total risk. It's
10 transferring -- and I prefer not to think of it as risk. I
11 think of it as accountability, accountability for the costs
12 that you can control to physicians or hospitals or PCPs or
13 specialists, but the pieces that they can control and not the
14 pieces that they can't control.

15 COMMISSIONER LAUFER: This is Noah Laufer again. I agree
16 with that and like that, and I would be willing to take on
17 performance risk and even some of the performance of the
18 people I refer to. The question is, you know, if, say, we
19 even have a five-year contract and we renegotiate, who is
20 going to tell me honestly how much risk I've taken or how good
21 of a job I've done because I imagine every year, you know, as
22 my patient population ages and gets sicker, I'm going to have
23 to renegotiate for narrower and narrower margins with another
24 entity, and I have to rely on their data to make my decisions.
25 I think that's where a lot of the anxiety comes from. We're

1 not insurance companies. I don't know what the risk is. I
2 don't want to take any more risks than I already do as a small
3 business owner. Does that make sense?

4 MR. MILLER: You're absolutely right. Where the biggest
5 problem is today -- and that's why I said at the very
6 beginning, number one is data and information because you
7 can't just suddenly say I'll take risk, but I have no
8 information on which to do that. You have to be able to say,
9 what are the things that I can control, which ones can I not
10 control, and be able to basically divide that up with a health
11 plan or payer and it has to be based on data? And if you are
12 -- for example, if you're in a multi-specialty group, you
13 could say, you know, I know my specialty colleagues, PCPs and
14 specialty colleagues, and we can manage that currently, but if
15 you're a PCP practice, you say well, I can control the things
16 I can control, but I can't tell what's going to happen if I
17 refer them to a specialist. I need to understand which
18 specialists are the highest quality, the most efficient
19 prescribers, et cetera.

20 So if you look at what Blue Cross Blue Shield of
21 Massachusetts has done -- and I think a major piece of their
22 innovation is not just a payment method, but the fact that
23 they have been extremely forthcoming with data and
24 information. So they have provided up front, to the folks
25 before they contracted, the data to help them understand what

1 the numbers were. They have been providing them with a really
2 excellent analysis all along the way, so that they could
3 actually identify where the problems were. And the other
4 thing that Blue Cross did in their contracts was that they --
5 this is not a very well-known feature, but they customized the
6 contracts and the risk transfer in the contracts to the
7 individual provider.

8 So some people had more extensive networks, more
9 experience in this new how to manage a broader range of
10 performance risk and so they could take on a contract that
11 took on more of that, but in other cases, they didn't, and
12 Blue Cross, unlike a lot of health plans, was willing to not
13 just have one standard contract, but to actually customize the
14 contracts to the individual providers, based on where they
15 are.

16 And I think, if you think about this in other
17 communities, you know, prices in rural areas are going to be
18 very different than prices in urban areas. Places where there
19 is competition amongst providers or choices amongst providers
20 are going to be different than places where there is not. And
21 I think that's why, to me, one has to start with getting
22 information and it has to be trusted, shared information that
23 everybody can use and figure out how to make a better plan.

24 CHAIR HURLBURT: Keith?

25 COMMISSIONER CAMPBELL: Yeah (affirmative). Keith

1 Campbell. I'm the consumer rep on the Commission. Let's go
2 back to your first few slides for some background. The
3 ACOs.....

4 MR. MILLER: If you can get a little closer to the
5 microphone, I'm having trouble hearing.

6 COMMISSIONER CAMPBELL: I'll swallow it. Anyway, the
7 ACOs are -- I guess they're a federal thing and they tend to
8 get set in concrete pretty quickly. I'd like to know where
9 the idea came from and who had the political muscle to
10 institute it in federal law, if you have that background,
11 please.

12 MR. MILLER: I missed about half of that. So you wanted
13 to know who had the idea and the political muscle for what?

14 COMMISSIONER CAMPBELL: For implementing and getting into
15 federal law the ACO ideas.

16 MR. MILLER: The ACO idea?

17 COMMISSIONER CAMPBELL: Yeah (affirmative), please.

18 MR. MILLER: Well, the Accountable Care Organization
19 idea, I guess, maybe Elliott Fisher gets the credit for it,
20 but it was basically (indiscernible - voice lowered). But the
21 idea was, if you're looking at a community and you know that
22 that community is different than other communities, which is
23 what the *Dartmouth Atlas* said, that they have -- like I showed
24 you the chart, you know, they are higher on some things. They
25 are lower on other things, that it varies within the

1 community, and in a sense, everybody is contributing to that
2 problem. How do you get that community of health care
3 providers to work together jointly in some fashion?

4 And so the notion of the Accountable Care Organization
5 really, initially, was simply a way to be able to pay for a
6 population of patients, not on a procedure-by-procedure basis.
7 And then it sort of started to morph into the idea of well,
8 what kind of an organizational structure do you have to have?
9 The original Elliott Fisher idea was that it should be all the
10 doctors who admit to a particular hospital. I think,
11 fortunately, it moved beyond that, but I think the problem --
12 to me, the fundamental problem with the ACO concept is that it
13 didn't start with saying, what exactly is it that we think
14 we're going to be doing differently for these patients? How
15 do you have to pay to be able to support that, which would
16 have immediately rejected the shared savings concept, if you
17 ask me. And then if you have a more nuanced payment
18 structure, who can take that and what, if any, capabilities do
19 they have to be able to do that?

20 But instead, we've tried to make a single big leap to
21 say, somehow, there should be one organization now that's
22 going to be responsible for everything, even though that is
23 not realistic in most communities around the country. And
24 then we can have a very simple payment system. I mean, the
25 dirty little secret about shared savings is it is very simple

1 for Medicare or a health plan to implement because they don't
2 have to change anything about the way they pay today. They
3 simply continue to pay the exact same way they do today. And
4 then you add up all the costs at the end and you compare it to
5 some number, and you say, if the number is lower -- if the
6 total costs are lower than what we thought they would be,
7 we'll give you some of it back. And it's that simplicity for
8 the payer, which is what makes it so problematic from the
9 health care providers' perspective because it doesn't actually
10 change the way they can deliver care.

11 But my answer to your question is, it was people looking
12 for a simple silver bullet solution to a very complex problem
13 and wanting something that they could do overnight, rather
14 than being willing to recognize that you had to do a lot of
15 different changes in a lot of different ways to be able to fix
16 a system that has developed over decades to where it is today.

17 CHAIR HURLBURT: Jeff?

18 COMMISSIONER DAVIS: Thank you. Hello, my name is Jeff
19 Davis, and I'm the President of Premera Blue Cross Blue Shield
20 of Alaska, and we're a part of Premera Blue Cross
21 headquartered in Washington. So thanks so much for your
22 remarks and that was a remarkable job going through some of
23 these slides so efficiently.

24 My head is spinning a little bit, I must say. What
25 you've laid out for us, I think, does resonate, but is

1 extremely complicated when you look at it from our vantage
2 point in the world. I am familiar with the Washington model,
3 you know, in a state with 10,000 physicians. And then here we
4 are in Alaska with, perhaps, 1,000 physicians and many, many
5 really small practices, mainly in Anchorage. If you look at
6 the number of primary care doctors, it doesn't, you know, it
7 doesn't come close to even the smallest examples we've talked
8 about today.

9 So one of the things I struggle with as we look at how we
10 will transform -- and we must. We've heard compelling reasons
11 for that as long as the Commission has existed and before, but
12 what I struggle with is how we do it with small numbers of
13 physicians and a small number of people and do it efficiently
14 and effectively because, you know, if you talk about bringing,
15 you know, infrastructure together to just organize and do the
16 data, I mean, even that scale seems almost beyond our reach.
17 So if you would, please, just spend a few more minutes talking
18 about your ideas as to how you would do this in a very small
19 population, such as exists here?

20 MR. MILLER: All right. Very good question, and I'll use
21 that to sort of re-emphasize a point that I made at the end,
22 which is there is no one-size-fits-all solution. I'm not
23 suggesting, for example, that the Washington State model is
24 right or maybe initially right for Alaska. What I think there
25 are around the country are a number of examples of very small

1 physician practices that do work together in some fashion,
2 including in rural -- across rural areas. So like Northwest
3 Physicians Network in Washington has got small PCPs and
4 specialists, including over some rural parts of the state that
5 are able to manage global payments because of the capability
6 that NPN gives them. That capability did not get invented
7 overnight, and I think that's why I say sort of the ACO
8 solution is trying to get a quick fix. I think that
9 communities have to have a multi-year strategy for being able
10 to get there.

11 Now I'll give you a couple of examples. So in Michigan,
12 for example, Blue Cross Blue Shield of Michigan started
13 several years ago what they call their Physician Group
14 Incentive Program, PGIP. And Michigan is very small onesie-
15 twosie physician practice state, and what they've started to
16 do with is to say, all we'll do initially is we're going to
17 provide money for quality improvement initiatives, but we will
18 give them to physician organizations, networks of physician
19 practices. You don't have to consolidate. You don't have to
20 form any kind of big delivery system, but you have to work
21 together on these quality initiatives, and if you do that, if
22 you create a structure to do that, we'll give you money that
23 you can use then as rewards for improvement, and you can
24 distribute it amongst yourselves. And they have \$100 million
25 a year now going into this program, which has helped to create

1 capability amongst these networks. Most of them were IPAs,
2 but there's some that aren't, to do that.

3 Care First, which is the Blue Cross plan in Maryland and
4 northern Virginia has just started in the past year, I think
5 again, a sort of very innovative program that says they're
6 offering some incentives, like to physician practices. They
7 can get more money up front, and they can have an opportunity
8 to share in savings. But in order to do that, they can't do
9 it as single physicians. They have to find -- they have to
10 partner up with others. They're going to have to -- not
11 partner in the sense of forming a larger group, but they have
12 to create a pod, or whatever you want to call it, of folks who
13 are working together so that they can share services. They
14 can share experiences, et cetera, and work like as if they
15 were part of a larger practice.

16 And I think that some of those models are going to end up
17 being more effective in rural, smaller communities where you
18 inherently have smaller practices spread over a larger area.
19 And what I think -- this is why you have to have sort of the
20 multi-stakeholder approach is because you have to say, what's
21 our problem in this community or our challenge? We have small
22 physician practices. We need to create a mechanism whereby
23 they can work together. They need to use telemonitoring
24 capabilities, whatever the solutions are. And then, how can
25 we create -- take these payment reform ideas and customize

1 them to be able to support those efforts to be able to move
2 down a path with an idea of where you want to get in the long
3 run? And I think that in the long run, to me, doesn't mean 20
4 years, but it doesn't mean next year. It means something in
5 the order of five to seven years. Maybe longer in some cases,
6 but I think you can make pretty significant changes in those
7 places.

8 And what my advice to you all would be is to -- you have
9 to think about both of those things. You have to say, what
10 would we like to be able to be doing in five to seven years,
11 what kind of payment structure would we like to have, what
12 kind of delivery system structure can we have? And then, what
13 are the transitional steps that we can put in place to be able
14 to get there? And you have to have both because the
15 transitional steps by themselves may not go in the right
16 direction, if people don't know where you're headed.

17 We're starting this initiative next year with primary
18 care practices because we want to build the capability for
19 them to take more global payments at five to seven years.
20 It's a very different statement to primary care practices than
21 here is thing, new program we cooked up for next year, and
22 we're not going to tell you what happens after that.

23 But the converse is you can't say we want to do
24 comprehensive care payments, and we're going to do in five to
25 seven years, but you know, nothing along the way to help you

1 be able to get there.

2 So defining where you want to get and putting
3 transitional steps in place and the traditional steps are
4 tuned to the specific structure of payers and providers and
5 patients and businesses in your community, I think, is really
6 critical, and it's why, I think, these things all need to be
7 customized at the local level.

8 COMMISSIONER DAVIS: Great. Thank you very much, Harold.

9 CHAIR HURLBURT: This is Ward Hurlburt. I'm the Director
10 of Public Health here in Alaska.....

11 MR. MILLER: Hi.

12 CHAIR HURLBURT:and I have a history of being on
13 the delivery side and also on the health plan side. And is a
14 part of what you're talking about and a part of the role for
15 the collaboratives a way to build trust, because Dr. Laufer,
16 as a physician, says, who can help me in an honest, credible
17 way to understand how much risk I can prudently accept because
18 I can accept that taking some of this risk will enable me to
19 do a better job of keeping people healthy on that, and
20 probably -- and sitting right next to him is Jeff Davis, who
21 is the President of the dominant commercial plan here in
22 Alaska -- it's probably easier for Jeff to say trust me in
23 that than it is for Dr. Laufer to accept that.

24 You used -- one of the three examples you've given is
25 Northwest Physicians Network, NPN. They're out of Tacoma.

1 And in their history, they had a difficult time, at times,
2 partly because of their accounting, partly for other reasons,
3 partly for learning how to take risks. But if the health
4 plans that had contracted with them, and in reality, partnered
5 with them had not gone in and worked with them and said it's
6 just as important to us that you not fail as it is to you
7 physicians in NPN, that, if you can get to that level of
8 trust, then it seems like some of the things that you're
9 talking about can work. But as you've seen things around the
10 country, how do you get there? How do you build that level of
11 trust? And I would say probably the hardest place to build
12 that trust is on the physician side, where health plans are
13 often the enemy.

14 MR. MILLER: I think you're absolutely right. The trust
15 is -- in some ways, trust and culture are probably the core of
16 all of this. And you know for whatever reason, it is what it
17 is. You know, providers don't trust health plans. Health
18 plans don't trust providers. Doctors don't trust hospitals.
19 Hospitals don't trust doctors. (Indiscernible - voice
20 lowered) And so a part of the issue is you've got to get
21 people to trust each other to be able to move forward on some
22 new initiative that involves risks to everybody because this
23 is all -- this is threatening to doctors. It is threatening
24 to hospitals. It is threatening to health plans. It's
25 threatening to consumers. It's all-threatening to everybody

1 because, if it goes in the wrong direction for any of them, it
2 could bankrupt them, kill them, or whatever. So you have to
3 have some mechanism.

4 Part of my thing is I think there are win-win-win
5 solutions to all of this. Win-win-win doesn't necessarily
6 mean that everybody gets the same amount of revenue that they
7 do today, particularly on the hospital side, but I think you
8 would need to make sure that people stay financially --
9 providers stay financially viable. But everybody has to come
10 to the table and say, how can we design this new structure in
11 a way that will be beneficial? And you're absolutely right.
12 I think health plans -- that's why I gave the example of Blue
13 Cross Blue Shield of Michigan basically said it is in our
14 interest to have physicians develop this kind of capability
15 and not to get hurt in the process. So how can we create a
16 gentle transition system for them that enables them to do this
17 while they are still struggling to take care of patients, but
18 it enables them to get to that point?

19 So it can be done without the facilitator, but I think
20 that what a lot of communities are finding is having a neutral
21 table -- that's the regional health improvement collaborative
22 concept. I mean, it can be implemented in a variety of ways,
23 but a neutral table that, basically, everybody trusts and it's
24 goal is to be the trusted entity that says, if you get data
25 from us, you know, it's the right data. It's not something

1 that was biased in favor of the health plan or biased in favor
2 of the doctor or the hospital or whatever, so that people can
3 get on that path. For example, when you think about the
4 transitions with hospitals, that's a very different
5 conversation than most hospitals and health plans have today.
6 You know, as opposed to negotiating over how much more or less
7 you're going to pay me next, it's, how can I actually
8 transition to a potentially lower volume and do it
9 (indiscernible - voice trailed off)?

10 CHAIR HURLBURT: I think Noah and then Wes, you've got a
11 comment, and then we probably better move on to our Panel
12 after that.

13 COMMISSIONER LAUFER: This is Noah Laufer again. This
14 trust thing is more than just -- it's more than just a trust
15 thing. I'm very well aware, if I go anywhere to negotiate,
16 I'm outgunned. More knowledge. More political power. More
17 money. More everything. And I'm not just risking money. I'm
18 risking my calling and the lives and quality of health care
19 provided to my patients and that's actually a bigger issue.
20 I'm not that quick a study, but watching business, non-profit
21 or otherwise, I'm learning. If I enter a trade, I want a
22 clearly asymmetric trade in which I win and my patients win.
23 Even if it goes bad, we win and that means financially as well
24 as quality of care. Otherwise, why do the deal?

25 MR. MILLER: I had a little trouble hearing that, but I

1 think the -- what we're finding in a lot of communities is
2 that what is really helpful right now is to be able to help,
3 particularly physicians, sort of envision what the different
4 system would be and what kind of changes are going to be
5 necessary to do that in the both information that they have to
6 have, but also the different kinds of relationships that they
7 have to have and the different kinds of accountability that
8 they have to have. And for example, I've been doing some work
9 with the Colorado Medical Society, and we had an all-day --
10 100 doctors from all over the state, a whole range of
11 specialties came together back in February to sort of talk
12 through, so how would these payment systems work for you as
13 doctors and what would you do differently?

14 And one of the interesting things that came out of that
15 was that, at the end, the doctors all said we're going to have
16 to change our culture. We're going to have to be thinking
17 about how to hold each other accountable. We're going to have
18 to be thinking about how to divide up money in a fair and
19 equitable fashion and not be blaming health plans for all of
20 that. And I think that's one of the things that the
21 individual stakeholder groups can do. I mean, I just
22 mentioned doctors, but I mean the medical society can do, the
23 hospital association can do, you know, the chamber or employer
24 group can do is to help each of their stakeholder groups think
25 about how to transition the way they behave and are structured

1 to be able to make this successful because, again, everybody
2 is going to have to change, but it's going to take time to do
3 that, and having some opportunities to have some safe
4 discussions about that, I think, will also help to facilitate
5 things. So I'm not sure whether I got at your issue exactly,
6 but I do think that that's a very important strategy to have
7 is to foster those kinds of conversations locally.

8 CHAIR HURLBURT: Thank you. One last question, Wes?

9 COMMISSIONER KELLER: Thank you, Harold, for your
10 presentation. Informative. I'm Wes Keller. I'm a
11 Representative. I do not have an extensive health care
12 background, and my job is to be a liaison to the Legislature,
13 which I might say is.....

14 MR. MILLER: You're breaking up a little bit on me. So
15 if you can get just a tiny bit closer to the microphone?

16 COMMISSIONER KELLER: My job is to be a liaison to the
17 Legislature, prime responsibility. Who will define what an
18 episode of care is? That's my bottom line question. Who will
19 define the condition "adjusted capitation" in your example?
20 Is that the regional health improvement collaborative? I
21 think I heard you deny that this would favor the larger
22 organizations, yet it seems, to me, that, if it was -- if this
23 is still -- if the lists of episodes of care and definitions
24 are not produced, if that's something that has to be
25 negotiated as we go, it seems like it's front end loaded here

1 to be pretty tough on your smaller providers.

2 MR. MILLER: Well, I think those negotiations -- those
3 definitions have to be negotiated on a multi-stakeholder
4 basis, and I think they have to be -- there has to be a
5 recognition that, in the short run particularly -- in the long
6 run maybe, we will get to the point where all episodes can be
7 defined the same, but I think that, in the short run, they've
8 got to be customized to individual communities and individual
9 providers. So you say, in our community or for my physician
10 practice, I think I can control these pieces of the episode,
11 but I can't control others. And I think, from the payer's
12 perspective, the payer has to be willing and able to say well,
13 you know what, right now, I'm not controlling any pieces of
14 that episode very well, and if you're willing to control these
15 pieces of it, that's great. Let me figure out how to help you
16 do that, even if you're not prepared to do the other pieces.
17 This is, again, rather than saying, you know, it's got to be
18 all or nothing.

19 And I think one of the unintended problematic
20 consequences of national efforts is that there is an effort to
21 try to come up with nationally-standardized definitions of
22 episodes and nationally-standardized definitions of quality
23 measures. And in many cases, it may be that you look at that
24 and you say well, I can't do that here. And we would be a
25 whole lot better -- I mean, you can have nationally-

1 standardized measures as a starting point, but I think you
2 should recognize that these things are going to need to be
3 customized to what an individual community or provider or
4 health plan or whatever can do and implement, and the idea
5 should be let's get something to happen and not let the
6 perfect be the enemy of the good.

7 So that would be advice is, you know, take matters into
8 your own hands. You can't do it for everything. I mean, you
9 shouldn't say run out an episode for every single thing.
10 Let's pick some areas where we think that there are some
11 opportunities for short-term savings where data suggests that
12 there are some things that we could control, where there is
13 some strong clinical leadership, and say let's go tackle those
14 things. If we need to define episode, let's define the
15 (indiscernible - recording interference) for that.

16 COMMISSIONER KELLER: Thank you.

17 CHAIR HURLBURT: Thank you very much.

18 MR. MILLER: Thank you.

19 COMMISSIONER ERICKSON: Thank you so much, Harold. Are
20 you going to have some time to stay on the line for a little
21 while with us this morning?

22 MR. MILLER: I can, if you will let me listen in. Sure.

23 COMMISSIONER ERICKSON: Well, what we're going to do is
24 have a Panel right now, but I'm going to propose we take a
25 short break while they come to the table and give folks a

1 chance to stretch their legs and go in the other room for a
2 minute, if they need to. But what we have is a group of
3 representatives, local experts working in health insurance, a
4 private physician, a couple of hospital administrators, an
5 administrator from the tribal health system, who are going to
6 share some of their thoughts in response to your presentation
7 or just their thoughts about how payment reform in Alaska
8 generally can work, what the challenges and pitfalls might be,
9 what the opportunities are. So if.....

10 MR. MILLER: (Indiscernible - simultaneous speaking) You
11 should probably give me your phone number, so I can just call
12 into your line directly.

13 COMMISSIONER ERICKSON: I will email that to you during
14 our short break, and one of the things I just want to check in
15 on, if we're going to be shifting our agenda by about 15
16 minutes back -- and we'll just shorten our discussion time a
17 little bit for the group, but does that work okay for our
18 Panelists in the room to stay 15 minutes longer than what we
19 had originally agreed? I see heads nodding and thumbs up.
20 Very good. Harold, I'll email that phone number to you.

21 MR. MILLER: Great.

22 COMMISSIONER ERICKSON: Thank you.

23 MR. MILLER: Thank you, all.

24 9:40:11

25 (Off record)

1 (On record)

2 9:47:45

3 CHAIR HURLBURT: Could we maybe come back together? And
4 if the Panelists could sit at the south end of the table here?
5 Thank you. Yeah (affirmative). Bruce, you could just sit
6 there. I guess Jeff and Noah.....

7 UNIDENTIFIED MALE: (Indiscernible - away from mic)

8 CHAIR HURLBURT: Yeah (affirmative), if we could. There
9 are five seats there. That might be better, if you could.

10 The next portion that we have is called the Reactor
11 Panel, and I think that Harold Miller's closing comment in
12 response to Representative Keller's question was a nice segue
13 because we want to talk about how does what Harold talked
14 about fit in locally in our setting here.

15 So for those on the phone, I'll introduce the Reactor
16 Panel that we have. Bruce Lamoureux who is here as a CEO with
17 Providence Alaska Hospital, and probably everybody on the
18 phone in Alaska knows, but Providence is the largest hospital
19 in Alaska, part of the Providence system that's throughout the
20 Northwest and California. So Bruce represents the larger
21 hospital.

22 Ryan Smith, who is the CEO of Central Peninsula Hospital
23 in Soldotna and the Kenai Peninsula, is here representing a
24 smaller hospital. In terms of Alaska, not a small hospital,
25 but in terms of most of the country, it would be that, but

1 with a fairly wide spectrum of services there and drawing from
2 a regional area on the Kenai Peninsula.

3 Jeff Davis is the President of Premera Blue Cross, the
4 commercial health insurer here in Alaska.

5 Michael Banks is the Acting Chief Financial Officer with
6 the Alaska Native Tribal Health Consortium. And Harold, again
7 for your benefit, the tribal health program here has really a
8 unique role in Alaska as in many parts of the country, but in
9 many ways, real rural health care in Alaska is a tribal health
10 system with a system of smaller hospitals around the state and
11 a referral hospital for that system here in Anchorage, a
12 system formerly operated by the government but now 100%
13 governed and operated by the various Native groups here in the
14 state of Alaska.

15 And then the final Panelist is Noah Laufer, who is a
16 physician and president of the 13-physician group Primary Care
17 Physicians here in Anchorage, and along with Jeff Davis, a
18 member of the Health Care Commission.

19 Deb, I don't know if you want to add anymore on that
20 before we.....

21 COMMISSIONER ERICKSON: Did you hear Harold?

22 CHAIR HURLBURT: Harold, are you on -- can you hear us?

23 MR. MILLER: I am on.

24 CHAIR HURLBURT: You're on. Thank you so much for
25 staying. I hope you had a chance, somehow, to get a little

1 lunch.

2 MR. MILLER: I'll be munching while I'm listening.

3 CHAIR HURLBURT: Thank you. Bruce, could we start with
4 you, please?

5 MR. LAMOUREUX: Thank you, Dr. Hurlburt. We've been
6 asked to take five minutes and answer a question or respond,
7 comment on the presentation we just heard. So I'm going to
8 answer the question about the opportunities and challenges for
9 payment reform from my perspective as a health system
10 executive, and I wish to begin with challenges, the challenges
11 I perceive associated with this.

12 My comments, both in terms of challenges and
13 opportunities, are borne out of experience as a health system
14 executive, which included a period of time in deeply
15 penetrated managed care market and familiarity with
16 capitation, risk-based payment systems, and the debacle that
17 was managed care, at least in the southern California
18 environment in the mid-90s to early 2000s.

19 So the challenges I perceive associated with our
20 circumstance include 1) inertia and abundance, changing in
21 light of an environment that is relative robust as far as its
22 economics, certainly when we compare to other areas of the
23 country, other micro markets; 2) a fragmentation of payers,
24 providers, continuum of care systems and structures. I don't
25 believe that one unified conglomerate is the answer, so I'm

1 not advocating for that, but to think that there is anything
2 less than access fragmentation right now, I think, would be
3 foolhardy. Third, an ability to extract information from a
4 sea of available data. We're drowning with data. We just are
5 not able to get information out of it. Four, a lack of
6 experience and competence managing risk. You can put a
7 different skirt or a different pair of pants on the woman or
8 the man called risk, and it's still the same person. So
9 understanding what risk is, how to manage it, and having the
10 competence around that is critically important. And last, but
11 not least, fear, fear of the economic implication of change,
12 fear of control. Who is going to control my destiny? We
13 heard, in Dr. Laufer's statements, his aspiration for an
14 asymmetric transaction wherein he wins and his patients
15 receive the care they so richly deserve. We all share in that
16 fear in some way, shape, or form. So those, I believe to be
17 our challenges.

18 The opportunities are to focus immediately on quality,
19 safety, and waste-reducing tactics, and the hospital is a
20 prime environment for that. Second, to design laser-like
21 transition experiments to develop system-ness, and I don't
22 mean controlled by one entity. I mean some form of virtual
23 system-ness, collaboration, and again, laser-like experiments.
24 Don't try to boil the ocean. Pick the skirmishes. Be wise.
25 Understand what you're getting to as best you can and then

1 learn how to manage whatever the risk model is. Third,
2 develop the infrastructure and competence around risk light.
3 We don't have the systems and structures and the actuaries and
4 the data and the ability to interpret those data at this point
5 in time. We have to gain that competence. Fourth, engage
6 patients as stakeholders in benefit design element because
7 it's not only about the payers and the providers, it's how we,
8 as individuals, engage as members of society and start paying
9 attention to our physicians when they tell us you ought to
10 quit smoking, you ought to lose weight, you ought to take your
11 medication. We don't do a good job, generally as a society,
12 paying attention. And last, but not least, developing
13 competence in health management within clusters. So
14 population health, how do we do that? How do we manage
15 chronic disease? So those are the opportunities I believe we
16 have. It will call for all of us to behave differently.
17 Thank you.

18 CHAIR HURLBURT: Ryan?

19 MR. SMITH: Good morning, I'd like to thank the
20 Commission for inviting me and Harold for his presentation. I
21 think there is a lot of great information. I think there is
22 absolutely nothing that I could disagree with, with what Bruce
23 just said relative to the challenges and opportunities.
24 Again, I think some recognition of those in a little bit more
25 detail is always helpful, from my perspective. And so when we

1 talk about -- I know one of Harold's slides was, you know, how
2 is Alaska doing? And so I think it's fair for us to, at
3 least, acknowledge and recognize that how we are doing is, I
4 think, very well in terms of how, you know, hospitals and
5 physicians have, you know, made our way really in kind of a
6 cost-based reimbursement system within this state. For a
7 hospital, like ours, you know, we're cost-based reimbursed for
8 Medicaid. We're cost-based reimbursed for Medicare, and we're
9 paid a percent of charge for our private payers. And so
10 everyone is doing very well, and what it means when everyone
11 is doing very well is there is a tremendous amount of inertia
12 towards any kind of change to that because everyone is doing
13 so well.

14 One of the slides that he had, you know, was, who should
15 be accountable for achieving higher value care? And you know,
16 two of those really aren't options for us because there are,
17 to my knowledge, no integrated delivery systems per se in the
18 state of Alaska, and I don't even know if there are any multi-
19 specialty groups. I think there are single-specialty groups,
20 but certainly not on the Kenai Peninsula. There is neither of
21 those, but there are health plans and hospitals.

22 And so you know, some of these slides of, you know, where
23 are we today versus where we need to go, we are clearly in the
24 column of, you know, fee-for-service and fragmented care, and
25 I think we should all just acknowledge that that is, you know,

1 where we are. The idea of going to episode and global payment
2 or Accountable Care Organizations is, you know, something that
3 could be a laudable goal for us, but we are far from that at
4 this point in time.

5 And then one of the potential solutions really had to do
6 with the physicians, and you know, talking about what are
7 potential solutions for physicians, and the options listed
8 were all physicians joining large groups, physician practices
9 are acquired by hospitals or small physician practices going
10 together in IPAs or virtual physician organizations, and I
11 don't know. You know, maybe Harold is comfortable presenting
12 those, but I suppose, if I gave this presentation to my
13 medical staff in the hospital -- you know, they already think
14 I'm the anti-Christ -- that wouldn't go over real well in that
15 group, you know, because of the inertia and the abundance of
16 what we have, but I understand it.

17 And so what all this really boils down to, for me, is
18 that I think we have some experience. At least in our area, I
19 can share what our experience was that got us to the point we
20 are today, which is, back in January 1st of 2006, the add-on
21 payment for Medicare, for the Medicare physician fee schedule
22 for physicians went into effect. It was eliminated, whatever
23 -- 30% or 35% or 40%, whatever it was, the add-on payment that
24 Alaska physicians got, and what happened over the next two
25 years in our market was that physicians stopped accepting new

1 Medicare patients on the Peninsula. Medicare patients ended
2 up, you know, showing up in the emergency room to receive, you
3 know, primary care treatment, and Medicare, obviously, didn't
4 care. You know, they don't care where the patient goes for
5 care. They're going to pay wherever they go, what the
6 mechanism is they pay to get that. I think the hospital
7 realized, you know, emergency room physicians are screaming
8 that that's not the most appropriate place for, you know,
9 patients to receive care. So we started to employ primary
10 care physicians and that's really led us to a model where we
11 are now employing about 25 physicians, almost in every
12 specialty, including the surgical specialties and primary
13 care.

14 And so through one change in a payment mechanism from
15 Medicare, we are halfway in building some kind of integrated
16 delivery system, and I know that's it's -- you know, it is not
17 viewed favorably by all. It is viewed as a way to control and
18 do different things. It's a good reason to move to Wyoming.
19 But anyway, what happens is that it was, at least, a mechanism
20 for change to start creating something that's different that
21 would allow what's behind this curtain to maybe be developed
22 in the future here. And so it is an impossible -- you know,
23 when people say, what keeps you up at night, you know, what
24 keeps us up at night is that, as an administrator in the state
25 of Alaska, with what's happening in the rest of the United

1 States is we've built kind of a pretty big cliff, you know,
2 because we're all about fee-for-service, you know, cost-based
3 payments here, and we're all doing very well. Our peers
4 aren't doing near as well as we are in the Lower 48, and we
5 kind of call that the Thelma and Louise cliff, but at some
6 point in time, we don't want that cliff to get so great that
7 we fall off of it, and you know, we throw the scarf over the
8 neck and jump off. We want some way to work towards getting
9 that reduction in payments or moving to these quality and
10 safety and waste reductions in a more responsible and
11 meaningful manner.

12 CHAIR HURLBURT: Thank you, Ryan. Noah?

13 COMMISSIONER LAUFER: I actually agree with a lot of what
14 both Ryan and Bruce said. I didn't understand why they would
15 like you're the anti-Christ until you told the whole story.
16 Now I understand.

17 MR. LAMOUREUX: Now you want to move away from me, right?

18 COMMISSIONER LAUFER: It's mixed feelings and emotions
19 for us as well. I mean, on the one hand, I'm delighted as a
20 primary care doc, you know, that I made the decision I did in
21 medical school to pursue primary care and become a family doc,
22 like my dad and the people I watched doing it. I love the
23 idea that it's being recognized by the country and that we're
24 maturing to a point that we think about health care
25 differently. And I do see it as a period of great

1 opportunity.

2 The problem is the change that purports to recognize the
3 importance of primary care is threatening our lives, and
4 actually, what we do, and in fact, the whole specialty of
5 primary care and that's reflected in the fact that fewer and
6 fewer people are going into it, and you know, we see a
7 solution and we're going to kill it by chasing it, apparently.

8 As far as Medical Park goes, we're all aware of this. I
9 think we're already doing a lot of the medical home type
10 things and focusing on primary care. We are ready to be
11 recognized for doing that. We're ready for a change of pay
12 structure. I've done everything possible to, you know, make
13 our little ship tight. We've eliminated debt. We've hired
14 good doctors. We've gone onto EMRs. We're meeting all the
15 criteria for meaningful use and everything, but we don't know
16 what the future looks like.

17 And like I expressed before, negotiating with anybody who
18 is significantly more powerful than we are is a very
19 frightening prospect. What I would like to do is keep it
20 safe. I can envision a future where we work collaboratively
21 with everybody better, but still maintain some of our Alaskan
22 autonomy, you know, libertarian autonomy, and I think, in an
23 ideal system, a primary care doc could come to town, hang a
24 shingle, log into a shared EMR which is shared with everybody,
25 all the specialists and insurers, and unknowingly participate

1 in a system that works. And I think, if doctors recognized
2 that, you know, this is your job, part of your job is not just
3 the acute visit, but the long-term care of your patients, they
4 would do it. I mean, there is not a group of people more
5 eager to jump through hoops than the people who went through
6 the socialization of, you know, doing well in high school and
7 college and medical school and boards and tests. You know, in
8 a sense, we want to please people. Everyday, 20 times a day,
9 I walk into a room with somebody and try to please them, and
10 I'm happy to do that, and we will do it, but it has to be
11 fair. And you know, it's the baby in the bath water; it can
12 easily be killed. We're doing what we can do. I appreciate
13 what you're saying, particularly Bruce's recognition of our
14 anxieties. Thanks.

15 CHAIR HURLBURT: Thank you, Noah. Michael?

16 MR. BANKS: I'm Michael Banks. I started in health care
17 two years after Medicare started. So I've been here -- yeah
18 (affirmative), I'm old. This -- Noah used to be my doctor
19 when I lived up here, you know. That's right. So anyway,
20 I've seen a lot of it, a lot of things happen over the years.

21 One thing I'd like to comment on the presentation first
22 is that there are, like, three distinct parts of the health
23 care system. People mix them all up, think they're all the
24 same thing. We have an insurance arm that takes care of
25 managing risk. We have a hospital arm that takes care of

1 providing hospital care, and we have a physician arm that
2 takes care of providing the professional component of health
3 care. So we're like the service industry, the insurance
4 industry. (Indiscernible - voice lowered) different. We
5 actually have three different businesses, you know, but
6 everybody says it's health care. It's health care you guys
7 are doing.

8 So I've been in capitation before, and I can assure you,
9 from my perspective as a hospital provider, it was awful. We
10 did a horrible job of accepting this risk and managing this
11 risk because, you know what, we provide health care. We don't
12 run an insurance company. These deal 100% of the time, all
13 day long, trying to figure out how to take a set of premium
14 dollars, all right, and use those premium dollars to get the
15 maximum amount of care out for their beneficiaries -- or in
16 their case, subscribers. So their job is to take a set of
17 dollars and say we need to get everybody taken care of that
18 we've accepted the risk on. Now if you're a bad risk, they
19 have the option of saying no; we don't want you in our
20 insurance pool.

21 COMMISSIONER LAUFER: They used to.

22 MR. BANKS: Well, they still do, to a certain extent. It
23 depends on what the plan says. Let's just say they have some
24 options. They have some options. Physicians some options
25 because I know physicians that have fired patients, all right.

1 When people walk in our emergency room and come in our
2 hospital, if we send them away saying you look like a bad
3 patient, you know, it looks like it's going to cost a lot of
4 money to have you in here, it's (indiscernible - voice
5 lowered) violation. You go to jail. I mean, Bruce would go
6 to jail if his hospital did that. They don't get the CFO;
7 they get the CEO.

8 So anyway, we are horrible at managing risk. When you
9 try to push risk to a hospital, it's disastrous, generally in
10 all the situations I've been in. I understand the concept of
11 everybody working together to manage the care for the group of
12 patients you're talking about, but to shift risk to me, in my
13 humble opinion, is a real disaster waiting to happen. The
14 same thing that Noah said, you know, how am I going to protect
15 myself? I'm not in that business. I provide patient care.
16 When I go in to see him, he talks about my medical problems.
17 He doesn't talk about, let's see, you're one of my 25 patients
18 in this plan. I've used up my quota. I'm going to have to
19 ask you to come back again in about a month. You'll be okay.
20 Anyway, it's a different concept of a portion of the health
21 care system. All right. Enough of that stuff.

22 I was told not to make any rash statements, but that's
23 just my experience. That's my experience.

24 The other thing we've tried to do in the past --
25 hospitals have tried to do, and I've worked for hospitals

1 almost all my career -- we've tried to buy physician
2 practices, and you know what? We're bad at that, too. We
3 don't manage physician practices very well. Physicians manage
4 physician practices much better. You know, he can skinny the
5 practice down. When he works for me, he works for a salary,
6 and it's like well, who is going to cover me when I'm gone for
7 three-week vacation? You know, it becomes an administration
8 problem, and we're not good at that either. So in my opinion,
9 we don't manage physician practices or risk very well. What
10 we manage is health care costs. Now you guys would say well,
11 you don't do a good job of that either, maybe. I don't know.
12 So enough of that.

13 The Native health care system here in the state of
14 Alaska, the state of Alaska has somewhere around 675,000 --
15 630,000 people in the entire state, how much?

16 COMMISSIONER ERICKSON: 710,000.

17 MR. BANKS: 710,000 in the entire state. The Native
18 population in the state is about 138,000 of that. So we're
19 going to represent -- our constituency, if you will,
20 represents maybe 20%-25% of the state population.

21 Our system, which is a hub and spoke, is already -- it's
22 been explained before, where we have a tertiary hospital here
23 in Anchorage and we have other hospitals out in the smaller
24 communities and then we have health aides out in the Bush.
25 It's designed to treat that entire population of people now.

1 One of the problems we have is our hospital, which 150-
2 beds, which doesn't sound big, but it's big in the state of
3 Alaska because Providence is 300 and -- how big?

4 MR. LAMOUREUX: 361.

5 MR. BANKS: 361, which would be a medium to large size
6 hospital in the Lower 48. Up here, it is the biggest
7 hospital, provides the most comprehensive care in the state.

8 The Native hospital here is the only level two hospital
9 still, I guess, right? I've been gone for a couple years, but
10 it's the only level two trauma center in the state, and what
11 that means is that there has to be certain infrastructure in
12 place in the hospital in order to treat anybody that comes
13 into the ED. I would say that almost 98 or so percent of our
14 patients are Native population. The other 2% represent people
15 that come through the trauma system and get into our hospital.
16 But basically, when I worked at the hospital, I had to go to
17 Providence to get my work done because I'm not a Native. So
18 it is a closed system. It's essentially a.....

19 MR. LAMOUREUX: Multi-specialty.

20 MR. BANKS: Yeah (affirmative), a multi-specialty
21 practice because all the physicians that provide practice and
22 tend to the patients are part of our system. They're
23 employees of the system. There is some specialty care that's
24 provided by outside physicians, but by and large, the care
25 that's provided in our system is by employed physicians.

1 Now there's a whole set of population that goes to
2 Providence and other hospitals that are Native population.
3 They tend to be covered by one of the insurance plans, Blue
4 Cross, Medicare, Medicaid, one of those insurance plans. And
5 so the Natives get treated in all places in the state, and we
6 tend to get either the people that don't have insurance -- we
7 get all of those, basically, not all of them. I'm sure you
8 get some, too, through the emergency system. Those patients
9 are treated by our resources that we have here in Anchorage.

10 And again, the payments that receive breakdown into three
11 classifications. We get payments from insurance companies,
12 third-party payers. We get payments from Medicare and
13 Medicaid, and I don't call them third-parties because they're
14 not commercial insurances. And we get payments from the
15 federal government for what we call core services. It's
16 called contact funding and that was when we originally set the
17 system, but we provided a group of services to our patient
18 population that was funded by a compact payment. That's still
19 in place and still covers a portion of that. But we have
20 certain regulations that (indiscernible - voice lowered) some
21 of these things we talked about in the presentation to work,
22 like co-pays and deductibles. We're required not to collect
23 those things. So there is really no incentive for anybody not
24 to come to us because, if they've got a high deductible plan,
25 you know, they come to us and they know they don't have to pay

1 that deductible. If they go to Providence, they've got to pay
2 the deductible. If they go to the Peninsula hospital, they've
3 got to pay the deductible.

4 So the system up here is funded a little strangely, I
5 guess, and it's different. Isn't that what people always say,
6 I'm different from everybody else? So in this case, we are a
7 bit different than everybody else. Our relationships with
8 third-party payers though tend to be just like everyone
9 else's. So from Premera's perspective, I think they would
10 love to do a risk deal with us, but again, I'm just -- like I
11 said, I've been burned so many times in my career that it's
12 very difficult for me to try to do that because it means I
13 have to create a set of resources to go look at things, other
14 than patient care things, and I prefer to use my sparse
15 dollars that we get paid in order to provide more patient
16 care.

17 CHAIR HURLBURT: Thank you, Michael, very much. Before
18 we move on to Jeff, I just thought I'd say, Harold, we wanted
19 to go through all five of these, so we'd have time for
20 everybody to get in, and then we'll have some discussion, but
21 maybe, Harold, after Jeff finishes, if you have any comments
22 or questions or observations on what any of the five Reactor
23 Panelists have said, maybe we could start with you and then
24 we'll open it up to the Commission members here. So Jeff, if
25 you could?

1 COMMISSIONER DAVIS: Thank you, Ward. I'm not as old as
2 Michael, but I did get my Master's in Health Services
3 Administration 30 years ago. And I was telling Noah earlier
4 that my Master's thesis was the beginning of Harold's
5 presentation, which, essentially, was, if you're going to do
6 this managed care thing, then what is really going to change
7 that's going to cause something to have a different outcome in
8 the real world? And apparently, I'm not as smart either
9 because 30 years later, we're still trying to find that
10 answer.

11 So this is complicated, but I think it's important to
12 stop for a minute and say, so why even do it? I mean, Ryan
13 aptly described the horn of plenty that we're all, you know,
14 kind of living in at the moment, but who is paying for that?
15 And it's our employer clients. It's all of us as residents of
16 the state of Alaska, and we heard from Commissioner Hultberg
17 and Commissioner Streur yesterday that we're on that Thelma
18 and Louise drive to the cliff. And so the bottom line of all
19 that -- and we've heard lots of other discussion around it is
20 that, from a cost perspective, it is not sustainable. Our
21 payer clients now are desperate. They're paying, on average,
22 if you look at small group populations, 65% more per person
23 per month than they would be if they were in Washington.
24 That's a lot of money, and employers in Washington are
25 screaming, so employers in Alaska are screaming very loudly.

1 And they want change, and they want it now. They feel like
2 they can't wait. So I believe it is the responsibility of all
3 of us around this table and in this room and as all Alaskans
4 to figure out what that looks like.

5 And I really appreciated Harold's comments at the very
6 end because I think that is where -- the end of his comments
7 is where I am now and where we're starting, which is we cannot
8 let the perfect be the enemy of the good. This is too
9 complicated for there to be a grand solution that will solve
10 it all with everyone brought to the table and neatly tied
11 together, but in fact, I think what we need to do is find some
12 things that work and that's going to be maybe different things
13 with different people. And I do believe that it starts with
14 primary care, and again, it's not some huge comprehensive
15 solution. It is I think we can effect this, this, and this.
16 We being the physicians.

17 I think it's, at this point in time for us -- you know,
18 30 years for my Master's, but 25 years working in Alaska, I
19 know that accepting risk is not a popular concept, and I don't
20 think it's a useful one really. I think, particularly when
21 we're thinking about primary care, the presentation we heard
22 from Dr. Dobson in North Carolina really struck home with me,
23 where they said we're going to pay the primary care docs' fee-
24 for-service and we're going to figure out how we can pay them
25 a little bit more to get the things that they need to practice

1 more effectively and efficiently and to have the kind of
2 impacts that Harold showed us that are possible to reduce
3 hospital admissions, reduce ER visits, and if that can happen,
4 we don't need to get hung up on the sharing of risk part
5 because, yeah (affirmative), that is really scary, and only
6 God can predict the future, and the rest of us are quite
7 imperfect at that.

8 So from my perspective, it is a search now between the
9 parties, whoever those parties are that are willing to try to
10 create a different future where the way things work in a real
11 world, in a physician's office, and in a person's life is
12 different than it was before, and let's figure out how to
13 bring the resources to do that. And we've heard -- again,
14 North Carolina was a perfect example. Bring a Pharm-D and
15 case management and maybe the hospital lists into an
16 arrangement with the primary care docs where they have shared
17 services and behavioral health is available to them, and as
18 Harold described, not worrying about how to pay for it because
19 it's already been paid for, and let's see if we can do a
20 better job with all of this.

21 So just reiterating what a lot of have said, but I
22 believe it is a "1,000 flowers bloom" type moment for us, and
23 everyone likes to be part of something that's successful. So
24 if you can come up with some models that work, then others
25 will be interested and willing to jump on the bandwagon with

1 you. So thanks for the time to comment.

2 CHAIR HURLBURT: Thank you, Jeff. Harold, do you have
3 any comments or observations or questions for us?

4 MR. MILLER: Well first of all, I thought those were very
5 helpful and insightful presentation comments from everybody,
6 and I think it speaks well to your ability to try to get some
7 things done, that you've got some folks who are as thoughtful
8 the issues and as open to different solutions as that.

9 I guess, you know, a couple things I would say is, first
10 of all, I think you have to start by saying, do you have a
11 problem you want to solve? If you don't think you have a
12 problem you want to solve, then there is nothing to do, right?
13 So the question is, is there a problem that the community has
14 to agree it wants to solve? You know, are health care costs
15 too high, whether it's for employers or for a state Medicaid
16 program or for individual out-of-pocket costs or whatever?
17 But that's where it all starts is we have a problem because,
18 if this is just, you know, some guy said that he thought that
19 there was a better payment system out there, you know, why is
20 anybody going to stop doing their day job to do that? They
21 have to think if they have problem.

22 Second of all is then there has to be a solution to the
23 problem, and the solution is not shifting risk or anything
24 like that. That's -- what I would say is then you've got to
25 then say, if we're going to reduce costs, where are the

1 opportunities to do that, given our circumstances? That's
2 where you need information, and the gentleman who said we have
3 tons of data and not much information is 150% right. We have
4 almost no information today to tell us where those
5 opportunities are that we could actually potentially reduce
6 costs without hurting patients and maybe, in many cases,
7 making them better off.

8 And then if we know what those opportunities are for
9 solutions, what exactly is the change that is necessary to be
10 able to support that? Sometimes, it's a payment change.
11 Sometimes, it's not a payment change. Sometimes, it's a
12 benefit change. Sometimes, it's just a technical assistance
13 change to be able to put that into place. And you know, I
14 would never even be talking about risk. Now that doesn't
15 necessarily mean that people don't take any risk. I mean,
16 everybody who spoke takes risks everyday. Hospitals take
17 risks. They take the risk that they're going to be able to
18 get enough money to cover the costs that they have to be able
19 to treat their patients. And Noah has got the risk to be able
20 to make sure that he's working enough everyday to generate
21 enough money to pay his employees as well as support his
22 family. It's not (indiscernible - voice lowered) risk. The
23 issue is that risk is the kind of risk that people can manage.

24 So that's the whole, I guess, message I want to try to
25 deliver is, once you agree you've got a problem, once you

1 figure out what the solution is, then how can you actually
2 give people accountability? And the risk is -- I mean,
3 accountability means risk, but the risk and accountability
4 that are within their capabilities to manage to be able to
5 achieve those solutions that will solve the problems that
6 people have, not try to somehow arbitrarily shift some large
7 amount of risk or whatever that goes beyond their capability
8 of managing it. And they may -- and I guess the other thing I
9 would say is you can't necessarily assume that you do all of
10 that based on the skills and capabilities that people have
11 today because, if you -- we have spent decades training
12 doctors and hospitals and health plans, for that matter, to
13 succeed under a fee-for-service system that drives volume,
14 that doesn't reward quality, et cetera, and you don't change
15 that on a dime.

16 So if you want to move to a system that starts rewarding
17 quality and better outcomes rather than doing more things,
18 people have to have the time to make the transitions, to be
19 able to learn new approaches, to be able to pay off all of the
20 capital investments that they've made for a different kind of
21 a structure, and that's why all of this takes time. But I
22 would start with, do we have a problem and then where are the
23 places -- the things that we could tackle? Whoever said let's
24 pick some things on them, absolutely. What are the biggest
25 things that you could do that would show some successes in the

1 short run rather than trying to invent some very large
2 overarching theoretical structure that misses the point?

3 CHAIR HURLBURT: Thank you, Harold. We'll open it up to
4 questions or comments from the other members of the Commission
5 now, but Harold, if there are other things that come up, we
6 would invite you to join in on this.

7 MR. MILLER: Thanks.

8 CHAIR HURLBURT: We have about 20 more minutes here now.
9 Any comments or questions from members of the Commission?
10 Yes, David?

11 COMMISSIONER MORGAN: This is a comment and then a
12 measurement question. I'm glad Michael is here.

13 The Indian Health Service is not that closed in the rural
14 parts of the state. They're usually the sole clinic, and they
15 do see everybody, and I think there are about 60 of them and
16 community health centers, which there are 25 programs in over
17 -- I can't remember -- maybe 150 clinics that are out there.
18 Half of them are owned or run by Indian Health Service. So
19 they basically, once they need hospitalization or specialty
20 care, they actually have two referral systems, one for their
21 non-tribal patients, usually with Providence or some other
22 hospital, and then the Indian Health patients, into Mike's
23 operation there at the hospital there, which I can throw a
24 football from my office and hit, by the way.

25 My question is, the North Carolina system and the system

1 I work in basically utilize HEDIS type measurements and
2 benchmarks. So I guess my question to the Panel would be a)
3 for your primary care operations in measuring outcomes and
4 moving to healthier patients, HEDIS doesn't count numbers. It
5 counts -- for these -- if you do these eight things on this
6 diagnosis, it makes them healthier, to give the audience a
7 little background. That's simplistic, but that's kind of --
8 so my question to the Panel, for your primary care activities,
9 are you using some type of measurement, and have you looked at
10 the HEDIS type measures, just like the North Carolina primary
11 care system uses? And that's -- in my mind, instead of
12 worrying about, if we really want to talk about patients and
13 making it better, that is a mechanism to work on improving
14 health by utilizing those measures for those diagnoses.

15 COMMISSIONER LAUFER: This is Noah Laufer again. That's
16 an excellent question, and I was thinking, you know, because
17 the discussion here has been so much about cost, I am
18 approaching it sort of as a business owner, as a physician,
19 but in fact, 99% of my life is not as a business owner. It's
20 as a physician. And I feel a profound sense of
21 accountability. I'm not scared of accountability. I feel
22 accountable to things.

23 The frustration is being in a situation where I'm
24 accountable, yet have no resources to help someone. And so
25 that's the real appeal of the North Carolina system is, you

1 know, I'm accountable, and great, I've got a Pharm-D to help
2 me with the transition to and from the hospital. I've got a
3 behavioral health person who can help me. I've got, you know,
4 a case manager who can help me, that helps me provide better
5 care to be more accountable and do a better job for my
6 patients. That's great, particularly if I'm not penalized for
7 it. I'm willing to take on the tougher, harder person who has
8 a personality disorder and a substance abuse issue and
9 socioeconomic disadvantage. Even though it would make my
10 stats look bad, I'm doing a good job and doing a noble thing
11 to help somebody who really needs help and that's great.

12 The problem with things like HEDIS is, who am I
13 accountable, to the documentation of box checking, to the
14 insurer, to the employer, to my other partners? You know, I
15 want to be primarily accountable to my patients. I want to do
16 a fantastic job for them, even if I don't document anything,
17 and I do. I get stopped in the grocery store. I get called
18 at night. You know, it's a pretty small place. And so there
19 are all these things I do.

20 I think it was Keith, you were talking about the doc in
21 Seward who worked 18 hours. You know, they didn't document a
22 thing, I guarantee it, and that's not how the world works now.
23 I have to document. And the idea that I'm going to be a
24 doctor for a system that wants to show that they need, you
25 know, this measure and that measure and this measure for

1 whatever, federal requirements or state requirements or system
2 requirements or to meet the demands of a grant, then your eye
3 is not on the ball, you know. I want to care for patients. I
4 don't mind documenting to a certain degree, but the focus
5 needs to be on good patient care, and I won't need the
6 resources to do that.

7 I would much prefer to chase the carrot of feeling good
8 about what I do and doing a good job and data that shows that
9 I am than to be hit with a stick.

10 CHAIR HURLBURT: Val?

11 COMMISSIONER DAVIDSON: I guess more of an observation
12 than a question. Well, maybe an observation and then a
13 question. I think everybody, no matter where they sit,
14 whether they're a primary care doc, whether they're a
15 hospital, whether they're an insurance company, shares the
16 same theme. We just want the best possible outcome for the
17 people that we serve. And the challenge is -- the statement
18 that comes next is, that's what we want, and there is some
19 variation that's either nice or not nice. If it's not nice,
20 then it's, but you fools over there, if only you would do
21 these things, then we would all be better off. If it's not
22 nice, then it's, if only we could work together to be able to
23 overcome these obstacles, then perhaps the people that we
24 serve, their health will be improved, et cetera, et cetera.
25 But there's this theme that sort of -- and there's a broad

1 spectrum, and I think, depending on whether -- what we've
2 eaten or where we're sitting or whether we're tired, we've had
3 a fight with our spouse or our kid or whatever, that message
4 changes at any given point throughout the day.

5 And I think the challenge that we have is we're all
6 individually really good in systems. We're really good at the
7 kinds of things that we're designed to do, but the challenge
8 is we're not necessarily talking to each other about those
9 kinds of things and what those outcomes might be, and if I
10 want to do something, how that might impact Noah's practice or
11 how that might impact Premera or how that might impact the
12 hospital or et cetera. And aren't these Accountable Care
13 Organizations and all of these other systems that are
14 designed, aren't those systems just merely a way to either
15 incentivize or to force people to come to the table to work
16 together? I mean, we call them very different things, and
17 they have a new name every five years.

18 It's like I used to be a teacher, and people used to say
19 no truly dumb idea ever dies in education. Well, let me tell
20 you; it's not only true in education. But we call -- I mean,
21 there's a reiteration every few years, and it's something
22 different. It was Managed Care Organizations. And so now
23 calling them different things.

24 The good news is we seem to be learning as we go, and
25 despite the name change, I think, until we get past that point

1 of we're doing the very best we can and coming to the table to
2 be able to say we are collectively doing the best we can, but
3 what kinds of things can I change that will make it easier and
4 will make it better for the people that we collectively serve?
5 And I think you can either do that by forcing it to happen
6 through things, like documentation.

7 The reason there is documentation is because, for a long
8 time, things weren't getting documented, and you know, the
9 pendulum has come full circle. And perhaps there is way too
10 much paperwork and way too much documentation, but that
11 happened for a reason.

12 Or you can do it by incentivizing, spreading the risk,
13 and then sharing the reward. And we can call it all different
14 kinds of names. I mean, I'm sure, in another five years,
15 we'll have another fabulous name, and it will be the newfound
16 thing. Yeah (affirmative), exactly. We'll call it something
17 else, but remember those old horrible Affordable Care
18 Organizations? Well, just like Managed Care Organizations
19 that were the evil in the '80s, in 20 years, we're going to
20 have a new system, but the common theme is, what are our
21 incentives to be able to work together and how do we do that
22 in a way that serves people that we all collectively care
23 about in a state, by the way, where it is challenging to
24 provide care, even in Anchorage? It's even more challenging
25 in rural Alaska. And for Harold, I mean, rural Washington is

1 not rural Alaska. It's very different. And then in an
2 environment where we have a large land base and a very small
3 population. So I probably said more than I should have, but
4 those are my observations and questions.

5 COMMISSIONER LAUFER: I just want to ask Valerie
6 something that I've always been curious about. The transition
7 at SouthCentral from patient to shareholder, what's the term -
8 - I forget -- you use? But the recognition that you are owned
9 by your patients, this must have resulted in changes in the
10 culture, and I would imagine some of them are positive. Is
11 there anyway to summarize that?

12 CHAIR HURLBURT: Can I respond?

13 COMMISSIONER DAVIDSON: Yeah (affirmative). I don't work
14 for SouthCentral Foundation.

15 CHAIR HURLBURT: I led that system when the government
16 operated it. I received my care there when the government
17 operated it. We provided high quality care. I was proud. It
18 is like night and day to go there now. The customer
19 orientation, the customer service, the relationship, the
20 attitude toward the users, the owners, the patients, be what
21 they may, is dramatically different and much better, I would
22 say.

23 COMMISSIONER DAVIDSON: But I guess the other observation
24 I would make is that we all have room for improvement. I
25 mean, we have tremendous opportunities for improvement in the

1 tribal health system. I mean, I make mistakes every single
2 day, like everybody else in the room, but we learn from those
3 mistakes and we move on.

4 The other observation I would make is that, I mean, there
5 are so many disincentives to people taking ownership and
6 control over their health care. I mean, even my now eight-
7 year old, who I've mentioned before, who has chronic
8 respiratory issues, had RSV when she was eight months old, I
9 mean, to be able to get her to carry her nebulizer at school,
10 to be able to allow her to be empowered when the earthquake --
11 not the earthquake, some other act of God -- when the volcano
12 was going off a couple of years ago, it happened the school
13 didn't have an emergency for asthmatics. The nurse had no
14 plan, and going to the school and saying, what is your plan in
15 case the volcano erupts? And oh, by the way, I may not be
16 here. I may be in D.C. And I was told well, we don't have an
17 emergency plan yet. In Anchorage, we don't have a plan.
18 Well, what are you going to do? Well, the School District
19 will let us know if the volcano erupts what we're supposed to
20 do. Well, what if the phones don't work? And then it was --
21 I said well, you clearly don't have a plan, but I want you to
22 know that I'm guessing that there are probably about 40 other
23 asthmatics in this school, this elementary school, and I'm
24 guessing you're not going to have time for my little Alana
25 (ph), so don't worry about her. She's going to be okay

1 because she does know what to do. And then her being so
2 concerned, based upon the questions that the nurse asked, she
3 decided that she was going to teach the nurse how to use her
4 inhaler and how to use her mask because the questions that the
5 nurse asked convinced a six-year old that the nurse wasn't
6 competent to provide her care and so she was going to have to
7 step in to help her friends. But I mean, that's just one
8 example. And there are so many incentives to encourage people
9 not to take ownership of their health care, and I'm wondering
10 -- I'll stop there. I mean, how do we go about doing that
11 without making people feel like they're incompetent? Or we
12 talk about personal engagement, and I mean, it just feels like
13 somebody is -- you know, it's really -- it's your ownership
14 and your stepping up and doing something, and it's not
15 somebody wagging their finger at some poor person who can't --
16 doesn't have money to take the bus to go get meds for her
17 kids.

18 COMMISSIONER MORGAN: My question wasn't to try to force
19 anybody to do anything. My question was purely a technical
20 question, based on the North Carolina and our experience. I'm
21 not speaking for SouthCentral, but I work there. It's like,
22 you know, I'm not a doctor, but I've spent a night in a
23 Holiday Inn.

24 At the North Carolina experience or any -- by the way, I
25 was in Barrow and helped in a transition of the Barrow

1 hospital over to control to the ownership of the tribal
2 members there. I, basically, did their business office and
3 medical records. It was sort of like -- I think the shock and
4 awe of just suddenly being in charge and having a board, and
5 suddenly, people are on a board running -- you know,
6 basically, the board of directors of a hospital. Suddenly, I
7 noticed people walking down the hall at 5:30 in the business
8 area, even if they weren't working there, turning off lights
9 suddenly, if you know what I'm getting at here. Ownership
10 changes attitude totally.

11 But no matter -- and even in this presentation, you had
12 to have some measurements. And what I've found over the
13 years, wherein you use something like HEDIS, that's it's not
14 used to beat up -- it works when it's not used to beat up
15 people, but as a tool to help you get there, in that, if there
16 are asthmatics, that we have this list of things to work with
17 the family, to work with the child, to work the pharmacy, you
18 know, to do -- and if you do that, suddenly -- if you do check
19 those boxes 70% of the time of the patients, that the amount
20 of visits to the ER goes down. So it was not a question of --
21 even if we weren't dealing with these reimbursement issues, my
22 question, again, is, to all the Panel, for your primary care
23 area, except for Jeff who doesn't have a primary care area, I
24 guess, do you have a measurement, do you use HEDIS to help you
25 get there, or whatever you use? I guess that's a pretty

1 convoluted question, but just that idea of we know we've got
2 to do these things, even if we don't have ACOs, but to get
3 there from a primary care standpoint, you've got to have
4 benchmarks or a system of knowing that you're measuring the
5 improvement and working with the patients to get there. You
6 understand what I'm.....

7 MR. MILLER: This is Harold. If I could just jump in and
8 say something, I think this issue of what to measure is really
9 very important, and the problem with HEDIS measures is that a)
10 they don't, in all cases, get at what it is you really need to
11 get at. They are measuring what people have figured out how
12 to measure, and they aren't always connected to the outcomes
13 that we would really like to focus on right now.

14 So if we're trying to both save some money and deliver
15 better patient care, then what we should be looking at are
16 things like how often are my asthmatic patients being
17 hospitalized, how often are they going to the ER, how often
18 are my congestive heart failure patients being hospitalized,
19 how often are they going to the ER, and that is not in the
20 HEDIS measures. And most primary care physicians don't have
21 the vaguest idea what those vague measures are in terms of
22 hospitalizations and ER visits because they can't get access
23 to that information.

24 But I ran a project here in Pittsburgh where I'm based,
25 for the Pittsburgh Regional Health Initiative over the past

1 several years, where we focused specifically on reducing
2 readmission rates, and we were quite successful. We reduced
3 for COPD patients by 44%, but it was by focusing on that
4 measure. The measure was the readmission rates. And then
5 looking to see what it was that was causing those patients to
6 be hospitalized and what it is that we needed to do with them,
7 and in many cases, making physician practices chase some of
8 these other measures ends up actually being a distraction from
9 focusing on the things that will actually improve care for
10 their patients.

11 Now the other thing that's important to, I think,
12 recognize about things like HEDIS measures is that what they
13 do do is they focus on a lot of things that are longer term
14 prevention. And so we have to recognize that it's important
15 to be focusing on making sure diabetics are well-managed to
16 prevent problems in the future. But if we need to save some
17 money today, we need to be focusing on some other things that
18 will save some money today and having more balanced
19 portfolios, some things that have long-term results, but some
20 things that have short-term results. And I think that's an
21 area where hospitals in the community, the health plans could
22 really help by making sure that there are some data and
23 information and measures available, so that physicians who
24 want to try to have an impact on those things can get the kind
25 of data they need to know how they're doing and which patients

1 are having problems and how to better target their services.

2 CHAIR HURLBURT: Noah?

3 COMMISSIONER LAUFER: I'm sorry. I don't know that we're
4 representative of all the practices in town, but specifically,
5 HEDIS measurements, no. We have some very basic things that
6 we ask every time.

7 As far as the information that Harold was discussing, I
8 think the community is in better shape than one might think.
9 I do know when my patients are admitted to the emergency room.
10 Because we're a referral base, most referral physicians are
11 very good about keeping in contact with me. I get telephone
12 calls pretty much everyday. I would guess that the notes -- a
13 summary of the visit comes back 70% or more of the time, but
14 there still does need to be a lot more transparency. I don't
15 know how I measure up against my colleagues as far as
16 readmissions, other communities, other docs in the community,
17 other clinics, et cetera. And I definitely do not have any
18 idea what the financial impact of my referrals is on my
19 patients or their health care, you know, insurers. I really
20 don't. And I think that is deeply ingrained in the culture of
21 medicine. You know, I would like to go do a month or two with
22 Jeff or somebody else and see where the money goes now.

23 When I was a resident, residents are considered too
24 fragile to be exposed to the financial realities of medicine.
25 You're supposed to only learn the medical aspects and never

1 make decisions based on finances. It's really part of our
2 culture and that may still be true, but it would affect my
3 thoughts, if I knew that, you know, one referral was going to
4 cost \$12,000 and somebody similarly could do it for \$8,000.
5 It might change my mind in sending them to the \$12,000 person,
6 but I would discuss it with the patient probably because it's
7 relevant to them. And many, many times, people come to me
8 with these itemized bills from admissions, and I mean, I'm
9 embarrassed to be a part of that and shocked by the numbers
10 there. You know, they're bankrupting, frequently. That could
11 be much, much more transparent, and you know, good relevant
12 data to care would be -- I would be delighted. I know it's
13 there.

14 Actually at one point about six years ago, Jeff offered
15 to show my practice some of the information they had on our
16 patterns, and everybody got very upset that we're being
17 watched that closely, and we didn't end up wanting to even
18 know what they know, that they're watching, which is very
19 interesting to me. I think they're more open now, but you
20 know, we were scared, so we stuck our heads in the sand and
21 told him to go away.

22 COMMISSIONER HALL: Jeff, are you willing to talk a
23 little bit about what you do have? I mean, there's a been a
24 lot of discussion about there is data, but nobody accesses it.
25 Nobody really analyzes it. We don't put it together to reach

1 some of the quality measures. And I understand, Noah, what
2 you're saying. It's the same reaction I saw yesterday when we
3 started talking about costs and Milliman specifically showing
4 costs of procedures. I've done of that with the entities we
5 regulate and was very hesitant to use it because I know the
6 reaction. So you don't even have to answer the question, if
7 you don't want to, but I think some of this is the kind of
8 thing we need to talk about.

9 COMMISSIONER LAUFER: Just very quick, a historical
10 thing. I worked with a gentleman named Ed Wong, who is a
11 Clinical Pharmacist at the hospital I did my residency
12 training at and was an incredible and invaluable employee who
13 the hospital, of course, didn't recognize his value, and he
14 left and went to work for Blue Cross for some multiple of his
15 income, and I know what he knows because I talked to him, and
16 he knows a lot about how we practice, particularly in regard
17 to, you know, easy ones, like diabetes. But you know, I
18 changed the subject to something else.

19 CHAIR HURLBURT: Maybe Jeff, if you could respond to
20 Linda, and then Bruce, and then we probably -- and then Deb
21 has a question. So Jeff and Bruce?

22 COMMISSIONER DAVIS: It's not often your Chief Regulator
23 says you don't have to answer the question, if you don't want
24 to, but I will anyway.

25 So I think, you know, there are a lot of myths in health

1 care, and one is that your health insurer knows everything.
2 And the truth of it is, as Bruce put it, there is a lot of
3 data and very little information, and the data we have is
4 everything that's claims and that's a lot of information. But
5 it is rare, and it takes a lot of effort, at least to this
6 point in time, for us to turn that data into meaningful
7 information. And what Noah was referring to -- and I do think
8 that the next generation has a different view of this -- is
9 that we have worked to put together information, worked with a
10 group of physicians in Washington to say, what do you want to
11 know? What would change the way you practice medicine? And
12 they told us, and we figured out a way to do it. And so we
13 thought well -- I thought well, if this is useful in
14 Washington, it should be useful in Alaska, right? One of the
15 many times I've learned that lesson.

16 So we put it together for the practices that were big
17 enough to have credible data, which is, you know, an issue
18 here. There aren't that many, and Medical Park Family was
19 one, and brought it to them, and Noah can describe the
20 reaction, and did, much better than I would. So we sort of
21 abandoned that, but what I'm thinking, as we have this
22 discussion, is I hoping that there are others who will want to
23 sit down with me and talk about this to have that same
24 conversation and say, what would be useful to you? You know,
25 what do you think you can change, and what would be a measure

1 that would tell you if you changed that? And then let's go
2 back and see if we can figure out an easy way to mine that
3 from the data that we do have and turn it into information.
4 So there is a lot that's possible, but you know, we're -- our
5 part of this equation is always, you know, you all are too
6 expensive and you don't need to make so much money. Well, you
7 know, 1% average profit over 18 years probably doesn't fit the
8 egregious profit model, and we've actually reduced our
9 administrative expenses as a percent and we've reduced it in
10 real terms by working hard to be leaner. That's a big part of
11 what we need to do.

12 So when we talk about more data, more information, there
13 is an expense to that because people who do that and do it
14 correctly are expensive resources, but I believe it's what we
15 need to do here. I think we're at the point of saying -- you
16 know, clients are saying we can't do this. It's not about
17 negotiating harder because we all know what market power looks
18 like in this market, and it's not with us. It's got to be
19 about fundamental transformation, and I've been convinced that
20 that starts with primary care and then goes on from there, and
21 it's going to require an investment, not just rearranging the
22 dollars, but an investment to make that happen. So that will
23 -- (indiscernible - voice lowered) requires some data --
24 information. Excuse me. Did I answer your question?

25 COMMISSIONER HALL: Yes. Thank you.

1 CHAIR HURLBURT: Thank you, Jeff. Bruce?

2 MR. LAMOUREUX: Thank you. In answer to the question, we
3 do not have HEDIS across all our employed physician group
4 areas. We have some of those measures and other measures, but
5 again, it's inconsistent. Congruent with other speakers'
6 comments, they're really surrogates for care and quality and
7 so how much utility you can get out of that is certainly in
8 question.

9 Everyone on the Panel is a rational economic actor, and
10 the fact that the payment system is not rewarding the desired
11 behaviors is a fundamental problem, and until it changes, no
12 one in his or her right mind ought to expect a whole lot of
13 change in behavior. It just isn't going to happen, and we
14 need to quit kidding ourselves about it.

15 So we need to jump into this. People are getting ticked
16 off with lack of affordability. Employers are upset because
17 of lack of affordability. I don't like paying more for care.
18 It's becoming more unaffordable, and I'm in a privileged
19 category as far as income. So you know, if I'm not liking it,
20 imagine the single parent on a nominal income who is
21 struggling to decide whether it's health care or paying the
22 utility bill this month.

23 So like other great societal movements, whether it's the
24 right of women to vote or the abolition of slavery, we're
25 going to get enough of a ground swell at some point, and we

1 collectively, payer, provider, wherever you sit in health
2 care, are going to get our butts kicked. So it's coming to a
3 theater near us, and we can either sit on the sideline, and
4 you know, watch this go on or we can jump in and start doing
5 some things. It's going to call for collaboration. It's
6 going to call for shared sacrifice, and if any of us think
7 that ACOs or any of these other models are anything but risk,
8 anything but stretching a dollar to cover more in the way of
9 care, we're deluding ourselves. So that's what I think about
10 HEDIS.

11 CHAIR HURLBURT: We transcribe these meetings, and we
12 will frame that, Bruce. Thank you. Well put. Deb, you have
13 a question?

14 COMMISSIONER ERICKSON: Well, I think Bruce maybe just
15 answered my question. I was going to go back to Bruce's very
16 first comment and then Harold's very first comment in response
17 to the Panel, that there is inertia right now because of their
18 abundance. And then Harold's first comment is our first
19 starting point has got to be, do we agree, as a community,
20 that we have a problem?

21 And so my question -- just a real quick story. I have a
22 small group of friends. Several are physicians, and one is a
23 hospital administrator, and we talk about my job periodically,
24 and they say you're doing health care reform. I say I'm not
25 doing anything. I'm a policy wonk. I organize meetings. I

1 read and write. That's all I do. I'm not doing health care
2 reform. You guys are the ones who are going to have to do
3 health care reform, the physicians and hospital administrators
4 in the room. So the physicians and the hospitals
5 administrators and the insurer at the head of the table, is
6 there agreement amongst all of you that we have a problem, and
7 is there enough agreement and do you feel strongly enough
8 about that, do you think we're ready to actually move forward
9 with working on some solutions together?

10 MR. LAMOUREUX: Yes. Absolutely.

11 COMMISSIONER DAVIS: No doubt. A sad story, from my
12 point of view. We were informed two weeks ago that a client
13 we've had for 13 years is leaving us, and I would say that the
14 root of that decision is their inability to continue to pay
15 what they're paying today for the health care for their
16 employees and their almost desperation to find solutions right
17 now, and they were willing to try something else because of
18 that desperation and that is a new phenomenon in my experience
19 in Alaska, 15 years here now, that clients are really to that
20 breaking point.

21 And so I absolutely think we have a problem. I
22 absolutely believe it is unsustainable, and I intend to spend
23 the rest of my career here trying to fix that, and it won't be
24 fixed when -- as my wife told, she's moving to Wenatchee, and
25 hopefully, I'll come with her, you know, 11 years from now.

1 We'll see, but not about will I go with her, but will she go
2 apart, since we're transcribing it. But you know, will it be
3 done in ten years? No. It won't. It took us a long time to
4 get here. It's going to take us a long time to get out of
5 here, and I think it's -- I agree with Bruce. We have to just
6 start with some things we believe will work, and if they work,
7 great. Build on them. If they don't, abandon them and find
8 something else, but we have a big problem.

9 CHAIR HURLBURT: Thank you. Harold, I wonder if you have
10 a final word for us? And then we'll break.

11 MR. MILLER: I only have one final word and then I have
12 to go, too, but I think that what you're doing right now is
13 exactly the way to get at it, which is to get all the key
14 stakeholders around the table, agree you have a problem, and
15 then try to figure out what some solutions are that will work
16 and to view it as -- I wouldn't quite say -- I mean, not a
17 long-term problem, I think, but you know, something that's
18 going to take several years to be able to, at least, put
19 meaningful things into place and to figure out what you can
20 get started right away. I think it's absolutely critical to
21 get some quick successes, as quick as you can make them,
22 because success breeds success, and if you can get some
23 successes in place, it will encourage more people to come to
24 the table to try to make that happen. So that, to me, would
25 be the strategy to follow.

1 CHAIR HURLBURT: Thank you, and thank you for staying
2 with us, Harold. We appreciate your presentation.

3 MR. MILLER: Thanks for the opportunity.

4 CHAIR HURLBURT: Yeah (affirmative)?

5 COMMISSIONER LAUFER: I need to comment on this. Again,
6 this is Noah Laufer, and I'm a primary care doc.

7 I think there is a problem, but to speak not just for
8 myself but for, you know, the community, first just for
9 primary care docs, it's quite flattering that we're being
10 recognized for the value that we bring, but you know, frankly,
11 there are not enough of us. We don't have the resources that
12 we should have. I'm in a dying specialty with dwindling
13 people showing any interest in it, and it's a very long
14 pipeline to get us here. And you know, alone, we can't solve
15 the problem. There are things that we need to do to improve
16 as well. That's one thing.

17 And then the other thing is, you know, medicine is
18 fragile, and it's not something people do, dally in, and then
19 go do something else. Primary care is important, but I need
20 the specialists, you know. Like I said, if someone is having
21 a heart attack, I can identify it and maybe stabilize them,
22 but they need a cardiologist and they may need an
23 interventional cardiologist. If they need an orthopedist,
24 they need an orthopedist. They need the specialists, and we
25 can't do it without them. And you know, there is this anxiety

1 about an attack on the medical community. We are capable,
2 able, willing to do a better job, I think, and I can say that
3 without having talked to everybody, but you know, it needs to
4 be fair. And if you expect primary care to solve all these
5 problems, we need to have the tools to do it, and there need
6 to be more of us. And if you want people to go to primary
7 care rather than other things or into medicine, for that
8 matter, there needs to be a fairly secure future. It's a huge
9 financial undertaking, a huge risk, and it's your life. It's
10 not like I'm going to try opening a small business, knowing
11 that it might fail. It's this is what I'm doing with my
12 entire life. It affects everything, when and whether you can
13 have children, whether you'll be financially stable. You
14 know, like I said, I'm 46. I just paid off my student loans
15 this month. You know, I'm at breakeven. And I can't get
16 disability insurance. If I get hurt, I'm out. And you know,
17 we need long-term stability and fairness. And if you want
18 people to go under primary care, it has to, you know, promise
19 a future of a noble and rewarding profession, not battered by
20 the winds of bureaucracy and random administrations and 20-
21 year trials of the next iteration of it failing somebody's
22 idea. I've said it enough, I think.

23 CHAIR HURLBURT: Thank you. Thank you, Panel, again very
24 much, and we'll take a brief break and then come back together
25 for discussion time.

1 11:01:56

2 (Off record)

3 (On record)

4 11:23:20

5 CHAIR HURLBURT: If we could go ahead and get started now
6 again? This last little over an hour that we have, I guess,
7 we want to go back over some of the things that we have been
8 discussing for the last day-and-a-half, particularly with a
9 view toward preparing our recommendations. So this will be
10 getting ready to prepare the draft on the recommendations.
11 There will be additional opportunity in our next meeting and
12 again following that again, but we want to make sure that,
13 when our recommendations for this year come out in January,
14 they're thoughtfully done, that we agree, so through the
15 things that we want to be saying to the Governor, to the
16 Legislature there. So Deb is going to try to lead this and
17 type, both. We'll be impressed.

18 COMMISSIONER ERICKSON: Well, it's been a pretty intense
19 day-and-a-half, and it's one of the challenges and the
20 tradeoffs. But again, just a reminder, we have a lot of time.
21 We did try to make more time at this meeting for conversation
22 and for drafting at the meeting just some preliminary Findings
23 and Recommendation statements, but without -- I don't want to
24 do too much process stuff. I would rather folks just kind of
25 freely throw out any thoughts or ideas that you have, and I'll

1 start capturing them. If we have enough time to see some
2 things, we can start pulling them together, but I think we're
3 going to still have to maybe have a follow-up teleconference,
4 just an hour, to kind of -- after I do a preliminary draft, to
5 get them a little bit more, so then we have something better
6 in writing far in advance of next meeting where we're going to
7 spend a lot more time trying to refine what you'll mostly have
8 all in draft form before. So did that make sense?

9 I'm just going to ask you to -- and I thought we would
10 start with payment reform and then we can go back to some of
11 the issues we discussed yesterday, but since that's most fresh
12 in our mind -- and start with ideas related to findings. So
13 if there were any lessons that you pulled out from the
14 presentation this morning or from any of the reading that you
15 did leading up to today related to this topic, the materials
16 in your notebook, I will take a stab at keeping up with
17 capturing them on a slide. Jeff and then Emily?

18 COMMISSIONER DAVIS: Sure. Thanks. Boy, lots to talk
19 about here. So observations, just in random. One is that a
20 solution conceived in Washington D.C. is unlikely to procure.
21 We're going to need solutions that recognize that health care
22 is delivered locally and that are customized to our unique
23 circumstances. None of this happens quickly. It'll take five
24 to seven years to have really meaningful change, but that's
25 not a reason to not start. And that data will be important in

1 measuring real changes in the real world, but it's not about
2 data and it's not about risk. It's really about empowerment.
3 Just top-of-the-head thoughts. Thanks.

4 COMMISSIONER ENNIS: I've been impressed with the
5 continual emphasis on ownership of health care in working with
6 a patient to acquire and sustain that ownership. And when I
7 think of ownership of our health care, I recognize that there
8 are people who are very capable. They are, perhaps,
9 comfortable in life, whether it's financially, educationally,
10 et cetera. And then I see there are two other groups, those
11 that would like to have better ownership and management of
12 their health care, but simply can't do it. And there's a
13 third group that really doesn't think about it at all.

14 And so when we focus on those two latter groups, as I was
15 hearing the presentation today, I was thinking what would it
16 take to encourage greater ownership of health care, and I
17 jotted down five different things that I think we would need
18 to have in place.

19 One is ownership of health care requires education,
20 knowing what to do, how to do it, when to do it. It requires
21 ongoing support because, often, just one session of education
22 doesn't help. You need support during different circumstances
23 of life. It requires motivation. A person -- and I'm
24 thinking of a number of people I know and work with that
25 probably could do a lot better in caring for themselves, but

1 they've got to have the education, the support, and some
2 motivation for doing that, and it's going to be different for
3 different people. And then it's going to require regular
4 contact with that support system or support person or that
5 educator, when I'm thinking of people I know. It can't be
6 every quarter, every six months, one year, annually. It can't
7 even be at the time of, perhaps, the acute episode.

8 And lastly, it requires time with the patient or that
9 person, and it's the time, I think, that's going to be most
10 challenging for physicians or health care professionals or
11 care managers. We don't have really a care management system
12 and that is, I think, one way to get at that time with a
13 person, so you can ensure education, support, and some ongoing
14 contact and determining what are the motivating factors that
15 really will increase ownership of one's health care.

16 COMMISSIONER HIPPLER: Thank you, Mr. Chairman. Emily
17 mentioned motivation as a big part of taking ownership of
18 health care, and a big part of motivation is being properly
19 incentivized to choose the correct options for oneself. There
20 is a disconnect of motivation when you have a third-payer
21 system and that needs to be addressed.

22 COMMISSIONER DAVIDSON: I think we should also be careful
23 about disincentivizing sort of that personal empowerment and
24 personal engagement. So for example, we say things like the
25 cost to employers is really rising for health insurance.

1 Those aren't really employer costs. Those are employee costs
2 because the employers aren't providing a health benefit out of
3 the goodness of their hearts. They're providing it as a part
4 of their compensation package. So they're providing health
5 insurance as a part of their compensation. So who is really
6 paying for it?

7 And I think one of the challenges we have is that you
8 can't -- you know, nobody is saying, oh, these poor employers.
9 An individual isn't saying my poor employer. It's just tragic
10 that they are paying so much more for my health care. That's
11 not happening. And I think we need to be mindful sometimes of
12 the language that we use that sort of takes that ownership and
13 that empowerment away from the individual.

14 COMMISSIONER HALL: One of the findings I think we need
15 to include is the sustainability or the lack of sustainability
16 of the amount health care costs today. Not worded very
17 artfully, but we really need to recognize that we need change.
18 We cannot continue to afford as a society what we're paying,
19 the expenditures, for health care.

20 COMMISSIONER STINSON: On the part about incentives,
21 we've already heard now from different states and different
22 consultants, and there seems to be a fairly consistent message
23 on a lot of this.

24 One of the incentives that would be required to get this
25 going is, when you're trying to have a new payment system de

1 novo, that now is going to require additional personnel, such
2 as a nurse case manager, such as what they've done elsewhere
3 that's worked and has got data to work and it should work and
4 will work, most people can't suddenly say, in my clinic, we'll
5 add a Pharm-D, a nurse case manager, and maybe a behavioral
6 health specialist, and yet, it works. And it would work. It
7 would speed the process up.

8 If there was some way for -- and I don't know who, the
9 State, whatever -- to incentivize that, or at least a pilot
10 program or something along those lines, it would be nice
11 because we're all seeing what's worked in other states. It
12 would be nice to say yeah (affirmative), and it works in
13 Alaska, too.

14 CHAIR HURLBURT: I think, just to respond a little bit to
15 that, Medicaid is a big piece here, and in four locations, the
16 State Medicaid program is going to try, in the medical home
17 concept, to up front some money that could be used for some of
18 those kinds of things. It's not going to be broad-based. The
19 intent will be to pick four locations from different kinds of
20 health systems within the state, but it will be an attempt to
21 pilot, to try a small scale something that could fit in with
22 what you're suggesting, I think.

23 COMMISSIONER STINSON: When and where is that going to
24 be? How has that been publicized? Do other practices know
25 about that? Is it restricted to certain groups?

1 CHAIR HURLBURT: I think it would be primary care. As I
2 say, the intent is to come from -- represent different kinds
3 of systems. The timing will be this fall, so within the next
4 two or three months, and I think it will -- go ahead.

5 COMMISSIONER MORGAN: My understanding is an RFP will go
6 out. I believe -- I'm looking back at Mary back there -- that
7 one of the pilots is going to be focused in on community
8 health center types. There are the four pilots for patient
9 home that Medicaid is going to -- one of them is going to be --
10 -- they hope to have one from community health centers, I
11 think.

12 MS. SULLIVAN: Frontier, non-frontier, rural, non-rural.

13 COMMISSIONER MORGAN: Right. Right, but they're not
14 limited to any particular type of delivery, but I think the --
15 and I'm speaking from what I've heard in meetings, but there
16 will be four. Some will -- one will be frontier. One will be
17 like in a community health center type setting. One will be,
18 I think, tribal, if need be. One will be like -- a Noah can
19 go for one or something. I believe there is going -- they are
20 going to make it broad-based. I wish someone was here from
21 the Commissioner's office. Yeah (affirmative), broad-based.
22 They're going to provide some money to get there. There was
23 also a capital, some capital put in the last budget to help
24 community health centers develop patient home, which is RFP-
25 driven inside the Primary Care Association; have I got that

1 right, at least? Okay.

2 So I'm being kind of general on the other one because I'm
3 only hearing what the Commissioner said in some meetings. Am
4 I close on that?

5 CHAIR HURLBURT: Yeah (affirmative), and they're still
6 working out the details on it, and the timeframe is fairly
7 short on it, but they're still targeting trying to have it
8 this fall.

9 COMMISSIONER STINSON: Are those sites already
10 determined?

11 CHAIR HURLBURT: Are what?

12 COMMISSIONER STINSON: So physicians in the community, if
13 we were to let other people know about this, they could
14 participate or apply for this?

15 CHAIR HURLBURT: They're be an open RFP, but with the
16 intent of having the mix that was described. Wes?

17 COMMISSIONER KELLER: If I could make a comment on that,
18 that happened because of some very effective, I'm going to
19 call it lobbying, but first with the Governor and then with
20 the Legislature. And I just wanted you to know how the
21 process works. So anyway, it was an investment made on the
22 front end there to work through the Governor and get it in the
23 budget and then work through the Legislature to keep it there.

24 CHAIR HURLBURT: Valerie?

25 COMMISSIONER DAVIDSON: I hope that we remember, when

1 we're talking about payment reform and costs, that we're
2 actually talking about value. I think that people aren't
3 concerned so much about the high cost, so much as that they
4 don't feel like they're getting the value for the high costs
5 that they're paying. It's sort of the -- I've mentioned this
6 before -- flat screen TV phenomenon. Ten years ago, nobody
7 would have dreamed of paying \$1,000 for a TV, but people will
8 now to get a 3-D TV or some other kind of fancy flat screen
9 TV. So it's really a question of, what's the disconnect
10 between the cost and the value?

11 COMMISSIONER CAMPBELL: I remember our conversation
12 yesterday, and Wes hit on it. We need to design the convening
13 mechanism for a group to look at whether it be a mandate or
14 something to really put a group that can design this thing,
15 this beast, whatever it turns out to be, going forward
16 because, right now, whether it be this group or some other
17 group designated by someone that really is empowered to do
18 this. It's nice if you do it cooperatively, but until it's
19 somebody designated that has the ultimate responsibility, I
20 think, in my own mind, we're not going to get very far because
21 of the time constraints and all of these other things that
22 people are busy doing and other life. And if this is the life
23 of someone, this mechanism to drag us into the next century
24 here, we're going to have to have -- and I don't have any
25 concept of how that would be, but we had talked about, in

1 yesterday's discussion, some mechanism with some teeth to get
2 this thing moved forward.

3 CHAIR HURLBURT: To some extent, I think what we heard
4 yesterday from Commissioner Hultberg and Commissioner Streur
5 is that reflecting the state employees, retirees, and
6 Medicaid, which in the aggregate is a big chunk of the
7 purchasing here, they're coming together and an interest also
8 expressed from other parts of state government, much smaller
9 in dollar amount, but Workman's Comp and Corrections, in
10 looking at it. So that part of the payer portion is coming
11 together. Are you suggesting perhaps we should have some
12 recommendations related to that?

13 Then as having most of the commercial business in the
14 state, we don't have to have a whole lot of players to have a
15 major impact. It may well be that Medicare would be one of
16 the toughest nuts, since Medicare is almost all fee-for-
17 service here. We don't have the managed Medicare plans in the
18 state, and since that's the Feds, it would be harder for us to
19 impact on that, but we have a relatively limited number of
20 players in the state in terms of Premera having most of the
21 commercial business and the State being a buyer. There are
22 people who have expressed interest, I think, in pursuing what
23 you're suggesting, and perhaps we should have some suggestions
24 related to that.

25 COMMISSIONER CAMPBELL: Well, yes, and we heard this

1 morning about the willingness of providers to be in this
2 circle. So that's fine.

3 COMMISSIONER MORGAN: I think that, whatever the
4 recommendations are, we do need to, at least, break them apart
5 into short-term and long-term. Some of this is going to take
6 five to seven years, especially on the public health part and
7 the preventive part. But when you look at the graph and the
8 economic trends data, which the Commissioners yesterday agreed
9 is there, they basically took a regressive analysis and did a
10 line, but there's probably \$7 to \$10 billion of actuarial
11 costs coming, depending on the number of people that go into
12 Medicare or the changes in eligibility, that I don't know, at
13 least on in some areas or some concepts, we have five to seven
14 years.

15 I think we're going to have to make some short-term
16 recommendations in order to provide some tools for everybody
17 to use to begin showing some progress reasonably faster.
18 Systemic change does take time, but from what we heard
19 yesterday and what we've heard over the last year, there are
20 some things we can start to do and support that maybe we can,
21 at least, stop the trend line from going up, at least maybe
22 becoming -- change the trajectory, at least a little bit.

23 The other area is, especially with the three concepts we
24 heard in webinars, there are good things. There are bad
25 things, but try to get glean out of them as much as we can.

1 The reason you have six shots in a six-shooter is, sometimes,
2 you need more than one bullet, as someone aptly said. We need
3 to do a full court press, as they would at University of
4 Kentucky, in order to start the process on the long-term and
5 to start showing some short-term gains, and we're doing stuff.
6 They had -- unlike a lot of presentations, we did have some
7 solutions the State's doing. They did have the Medicaid task
8 force, which a lot of us attended those meetings. Those will
9 help, but there needs to be a lot more, and there's a lot of -
10 - some stuff we can do in the short run.

11 The second thing is I want to absolutely make sure,
12 because I actually did a little outreach and asked a few
13 people to come and give testimony yesterday from MGMA and some
14 other organizations that, sometimes, are not included. I
15 would think we want to absolutely make sure that, when we do
16 get our recommendations -- and probably some of us, including
17 myself, may have to get people to start our car in the morning
18 because of it isn't going to be popular. We all know that,
19 but that's -- and I think we have built in time, but let's
20 just be very cognizant that we need to have -- we may need a
21 bigger room. We may have a lot of people that want to give
22 comments. I think that will relieve some of the anxiety and
23 give them enough time to -- and you've been doing a good job
24 on the website. A lot of people look at the website. But we
25 just want to make sure that they can provide written comments

1 and can come and -- even if they want to talk about the gold
2 standard, maybe we'll have a little of that. We know that, or
3 fluoride. I think we need to have as much public input in
4 order to alleviate the nervousness over this. There is going
5 to be a whole lot of that anyway, but let's, at least, attempt
6 -- and we have. I'm not saying we haven't, but let's keep
7 doing the way we're doing it and make sure that they get
8 access. Let's have short-term/long-term. Let's come in with
9 some viable tools, if nothing else. We don't have to say what
10 measurements already get to where we want to go, but we want
11 to make sure that we've got some measurements, that people
12 will have some. I'm sure, in those RFPs -- I've not seen
13 them, but there is going to be a section on, what are your
14 benchmarks? How are you going to get -- how will you measure
15 quality improvement, and how will show the cost effect,
16 hopefully down, maybe? And it can't be hey, we had fewer ER
17 admissions. There's going to be some stuff in there to get
18 there. So I think we need to make sure we've got those tools
19 in there. So I mean, that's pretty much what's been going
20 through my mind.

21 We got some stuff in the last Legislature. We're going
22 to have those four pilot projects. We're going to have some
23 money going to some community health centers to help them get
24 to where we all want to get to on patient home. ACOs or
25 managed care and that stuff, risk, I think the real issue is,

1 what are we delivering, and what's the quality of it to the
2 patient, and how much does it cost? And I guess that's all I
3 really -- it's what little bit is in my mind after a year of
4 this, a couple of 7 o'clock in the morning conference calls
5 and stuff, like that. Keep up the work on the website, and
6 let's just make sure we build in a lot of time for people to
7 tell us what's on their minds, not just with the Commission.
8 And let's, all of us, get to some of these meetings, whether
9 it's MGMA or HFMA or the Hospital Association or Medical
10 Association, or I don't know, there is probably an insurance -
11 - no? There isn't? Well, but.....

12 COMMISSIONER DAVIS: It's lonely.

13 COMMISSIONER MORGAN: It's lonely? Well, you can come to
14 the MGMA one with me. But I think we also need to get out
15 into the public because people will come up to you and talk to
16 you and really tell you what's on their mind, but when
17 someone's typing them in and they're being written up,
18 sometimes, it inhibits people.

19 One person yesterday was very nervous, and it took some
20 talking into, but they came to the podium and talked. This is
21 -- that's hard, if you've never done it before. And so
22 sometimes, we're going to have to do a little outreach, too.
23 I think we are, but let's absolutely, all of us, do it.

24 COMMISSIONER KELLER: I'll make a stab at an idea here
25 that may be a bullet, and I'm looking for help maybe from Jeff

1 and Allen, but it seems, to me, like whatever payment reform
2 we do, we need to be very careful to protect the business
3 climate, so that small providers can feel free to come up here
4 and hang out a shingle and so that insurers can look at Alaska
5 and say this is a great place to go because there are
6 possibilities. And I know that's very broad, and I know
7 that's kind of underlying to everything else we've been
8 saying, but it just seems like there ought to be a special
9 bullet there, not to necessarily give an edge, but to make
10 sure it's a fair playing field for business.

11 CHAIR HURLBURT: I think that's true, and it's like some
12 of the things that Harold Miller said and we all said here.
13 We need to tailor our solutions to Alaska. And kind of like
14 he described Michigan, we do have a lot of onesies/twosies, as
15 described, for physician practices here, and we want to
16 preserve that. Probably a reality is that that will be
17 changing over the years because most current medical school
18 graduates are preferring an employed situation rather than an
19 independent private practice. If that trend continues, we'll
20 see changes, even here in Alaska, and in fact, we're starting
21 to see that now. But I think that, at this point in time, we
22 want to protect what you're talking about.

23 COMMISSIONER KELLER: Maybe it's naivety on my part, but
24 I want to see that trend change and go back more, too,
25 because, to me, the bottom line is -- you know, ultimately,

1 it's the person looking for a relationship with a health care
2 provider. It's smaller, you know. And so maybe I'm living in
3 the past, you know, and I understand. In fact, if you look at
4 the numbers, I mean, the trend is huge and will not be
5 stopped. I do know that, but on the other hand, I think that
6 competition in market forces is the solution. And so anything
7 we can -- that's why, you know, I, for one, like others,
8 always go back to Health Savings Accounts ideas because it
9 really enables a person to shop, you know, for health care.
10 And so even though I know that trend is there, you know, like
11 I say, I'd like to see it go the other way.

12 CHAIR HURLBURT: Yeah (affirmative). You know, Pat has
13 the story on Ketchikan there. The hospital didn't take the
14 initiative. The local doc came and said that I heard recently
15 of a needed specialist wanting to come to Anchorage, but was
16 not interested, unless they could come that way. So I think
17 we just need to be cognizant that that seems to be something
18 being driven by young physicians, as much as anything now, and
19 there may be that change. Noah?

20 COMMISSIONER LAUFER: Maybe I'm living in the past also,
21 but I agree with Wes. I think that that trend could be
22 changed, if there is stability. Docs are acculturated now to
23 be -- you know, to negotiate a contract with the
24 (indiscernible - voice lowered) and be employed, and part of
25 the negative aspect of that is, you know, I want to be paid,

1 usually salaried. Then what I'm, you know, competing for is
2 not more money, but more time off and less responsibility and
3 less accountability. You know, it's a predictable thing.

4 When I think, you know, God, this Commission thing, is
5 this worth my time, I'm still optimistic about it, and I
6 think, rather than just thinking about how to fix the current
7 system, we should all say, gosh, what fundamentally are we
8 talking about? You know, one view is that it's this
9 relationship with the doctor, and how could we do that
10 differently? And I am in love with Alaska's libertarian
11 strain. I'm not a libertarian. I'm a liberal, if I had to
12 label myself, but I still think that there is an answer there.
13 And if we really are willing to think out of the box, we could
14 do it here. It's a small community. You know, the rest of
15 the country knows we're crazy and are going to do some
16 bizarre, you know, weird frontier thing. They'll let us.
17 I'll bet they will. If it works, our governor could run for
18 president. You know, we really are in a unique position, but
19 we've got to think bigger than, you know, protecting the
20 current status quo, which is going off a cliff.

21 The last thought, and this is the important one, if we
22 live in a society in which people live to be 80, which we do,
23 and we want to do things, like intervene and replace joints
24 and stent arteries, and you know, on and on and on, whatever,
25 give permanent hair removal, maybe it's a noble pursuit and we

1 should accept that it's going to cost 19% to 20% of GDP while
2 the boomers are on the Pipeline, probably less after that.
3 But you know, that's an unreasonable thing to decide as a
4 society. I don't mean we should continue the way we're doing
5 it now. It should be cleaner, more rational, and evidence-
6 based and all that, but that's not a bad outcome, and it
7 wouldn't be a bad thing for Alaska to say we value high
8 quality of health for a long period of time, and this is what
9 we do for ourselves. I don't think that's a bad message
10 anyway. Thanks. I'm out of words.

11 COMMISSIONER DAVIDSON: I think we should also have some
12 kind of system where we measure whether we accomplish what we
13 thought we would. So for example, when we're done with these
14 whatever reforms it is that we want to implement, how is it
15 that we're going to know we were either completely successful
16 or a complete failure? So some kind of mechanism to be able
17 to measure our progress.

18 COMMISSIONER ERICKSON: I'm trying not to respond, but I
19 just wanted to make a note that that was something that we put
20 in -- it was one of our strategies that we're not -- haven't
21 talked about yet this year that we were going to do. And one
22 of the reasons, besides kind of running out of time -- but the
23 Institute of Medicine meeting I went to, I was talking with
24 them about that specifically, the team of consultants there,
25 and they said that they are working in partnership with the

1 Commonwealth Fund. The Institute of Medicine and the
2 Commonwealth Fund are working together to come up with metrics
3 for measuring health care system transformation and that they
4 expect to have that set of metrics done by the end of this
5 calendar year. So I was going to suggest that we move it from
6 our agenda for this year to the very beginning of our 2012
7 agenda and see what we can learn from their work.

8 COMMISSIONER DAVIDSON: I wasn't intending to define the
9 system, but I was saying that we need to have a system. Maybe
10 it can be developed later, but I think we would be foolish to
11 say we're going to do this great work and then not have any
12 plan for how we're going to measure that, so at least identify
13 that measurement is a part of testing our success because
14 we're really great at anecdotes.

15 CHAIR HURLBURT: Allen, any comments? You have the
16 freshest eyes and ears in the group.

17 COMMISSIONER ERICKSON: So any -- shall we move to
18 recommendations? I mean, some of the things -- that was a
19 little bit of a hodgepodge. We had beyond just payment reform
20 suggested, findings. It ended up being some process
21 recommendations, but that's okay. I'll weed all of that out
22 and clean it up. Anymore specific recommendation statements
23 for payment reform?

24 CHAIR HURLBURT: Jeff?

25 COMMISSIONER DAVIS: I think one, perhaps, could be that

1 the State, as a payer, continue with efforts to participate
2 and support pilots that lead to meaningful change.

3 COMMISSIONER ERICKSON: Can I ask a follow-up question?
4 Should we -- we've learned about a number of multi-payer
5 initiatives going on down south. In Harold Miller's
6 presentation, he made the point that, if there is just one
7 payer working on an initiative, it makes it a lot harder for
8 providers. Should this recommendation include some statement
9 about a multi-payer approach?

10 COMMISSIONER DAVIS: If I may, how about including
11 examining the potential for multi-payer approaches? We're,
12 obviously, not Washington. Maybe it would work, and maybe it
13 wouldn't. I think it should be looked at.

14 CHAIR HURLBURT: I think Noah, particularly, but not just
15 Noah, has commented several times about what we heard last
16 meeting about North Carolina, with a sense that there were
17 some things there that could well pertain to us. Is there any
18 suggestion that we try to pursue that further, so that we
19 collectively learn more about that?

20 COMMISSIONER LAUFER: I feel like that's still an
21 evolution, and you know, various parties are thinking and
22 talking and trying to examine that.

23 That first statement, support doesn't, Wes, necessarily
24 mean money. It may mean a sensitivity to a regulatory
25 environment that allows for things, like communication. You

1 know, there are difficulties in communication, which are built
2 in to the law, and you know, is it okay for me to go talk to
3 other primary care docs in Anchorage and not be doing some
4 sort of anti-trust thing that I'm not aware of? I vaguely
5 know about that, but I do know a group in Fairbanks got in
6 trouble for doctors talking to each other, which is absurd.
7 They paid fines, is my understanding; is that right? Does
8 anybody know more about that?

9 COMMISSIONER MORGAN: They violated the STARK (ph).

10 COMMISSIONER LAUFER: They did?

11 COMMISSIONER MORGAN: Yeah (affirmative), and from what I
12 could read, it really wasn't that bad. It was almost like
13 what you're describing. They weren't getting in a room and
14 fixing prices or something, but they got clobbered pretty
15 hard.

16 COMMISSIONER LAUFER: My understanding is that they
17 crossed the hospital and that's exactly the kind of thing -- I
18 am not in this to connive or to, you know, do anything, but
19 try and come up with something better, and if I end up being
20 clobbered by the State, you know, particularly if it's being
21 used as a mallet by somebody else, that is not productive.

22 COMMISSIONER STINSON: The Fairbanks' situation was a
23 gray area. The majority of the people were just allowed to
24 dismiss. The leaders were all fined and faced even harsher
25 charges, but those were dropped. And it's things, like that,

1 that stop people from communicating, and we have to
2 communicate.

3 COMMISSIONER LAUFER: Sensitivity, please.

4 COMMISSIONER HIPPLER: Mr. Chairman? Back to payment
5 reform, the majority of the State's expenditure, or a large
6 part of it, is the Medicare and Medicaid system, and I have a
7 question for you. Does the State have a robust fraud
8 investigation component to monitor this?

9 COMMISSIONER MORGAN: On my bulletin board in my group of
10 offices, people that work for me and with me, is this huge
11 matrix of all of the things that are going on, from rack
12 audits all the way down. I might PDF that to Deb to send out,
13 but it came back from our -- we have several members of my
14 staff that are certified coders, and they have an association,
15 and they had a person from the State come and handout -- and I
16 exaggerate a lot, but on this one, when you see it, it's this
17 long. It's that -- and there are two of them, and it has all
18 the things that are going to happen over the next 24 months of
19 types of reviews, audits from a Medicaid/Medicare stance. We
20 even had a CMS review. We have administrative match in tribes
21 where, if you do outreach to get people into Medicaid and do
22 time studies, you're given seed money to help them do that, up
23 to 50% of their salary costs. They came in and checked two
24 years of our time studies and the time cards, and they wanted
25 a list of everybody that they contacted. We do it; no

1 problem, but they are looking at a lot of stuff, and I imagine
2 our primary care physicians are getting those kinds of
3 inquiries, too. There is a bunch of that going on. I don't
4 think we have a lot of Medicare mills, like you would find,
5 necessarily, in Miami maybe or New York. I think a lot of our
6 stuff is more mistakes kind of, but.....

7 COMMISSIONER LAUFER: A follow-up to that, are there
8 areas of duplicity between state and federal government in the
9 places where the State maybe doesn't need to follow an audit
10 with a state audit? Maybe I'm thinking less is more.

11 CHAIR HURLBURT: Yeah (affirmative). I think the answer
12 -- you know, is there a robust anti-fraud capability? And
13 that's kind of a value judgment on that. There are, you know,
14 a small number of the members of the Legislature that have
15 been interested in this, and it raised questions, at times,
16 and then the State -- the Medicaid is what I know more about,
17 but I don't know so much about Alaska Care and the employees
18 on that, but the Medicaid program is certainly cognizant of
19 the risks of fraud, and I think try to be alert for it. We
20 don't have a big unit. I think part of it is, as David said,
21 you know, a week doesn't go by that you don't read about some
22 major medical fraud related to Medicare or Medicaid in states
23 like California, Florida, or New York, and I don't think we've
24 ever -- that that's been a big problem here. Clearly, we're
25 not without because we deal with human beings, and we'll see

1 that.

2 As far as the collaboration with the Feds, that, to my
3 knowledge, that Medicaid is the State's responsibility, the
4 Feds will come in for Medicare, and the other side of the coin
5 -- and I think it's not unfair, sometimes, to be critical of
6 some of the, particularly federal, anti-fraud efforts where
7 providers and nobody else really has any tolerance for fraud
8 in this ethical, moral business that we're in, but there are
9 enough anecdotal type stories of the FBI coming in, sometimes
10 with weapons, right into a busy clinic and totally disrupting
11 the clinic, and a presumption that the provider is guilty
12 almost until proven innocent. And that's been expressed a few
13 times in some of our meetings here, and I think there is valid
14 reason for saying that, not in any context of tolerating the
15 fraud that does go on.

16 So I think it's reasonable to believe that fraud has not
17 been a big problem here. There is a sensitivity in looking
18 out for that, but it's not a big function for the State and
19 Medicaid. Deb, do you have any different take on that than I
20 do? You've been here longer.

21 COMMISSIONER ERICKSON: Just a suggestion that it was
22 something on our strategy list for sometime in the future, and
23 if we want to study it more and understand it better, we could
24 put it on our 2012 list for documenting what's really going on
25 and spend some time studying that.

1 COMMISSIONER STINSON: I think it would be a good thing
2 for the 2012 list because I can tell you a family practitioner
3 on the Kenai and a family practitioner here in town, and
4 actually, other multiple people, there has never been a big
5 fraud case in Alaska, but if you put a decimal point in the
6 wrong place, if your signature is illegible, physician
7 signatures, or other things, when they come in, they will
8 always find something and then they will extrapolate it over
9 five or ten years, if they find one thing. And so everybody
10 that is investigated, including one family practitioner in
11 town who dared them to find something wrong, wound up paying
12 \$65,000, and actually, every single one of these people -- and
13 there was actually no real findings. It was the paperwork was
14 done wrong, but every single one of these people subsequently
15 dropped Medicaid or Medicare and become non-providers. So for
16 one of them, it put 200 Medicare patients out for, basically,
17 clerical errors.

18 The one thing I would say, again in the future, is, if
19 they could figure out non-punitive ways to do this, because
20 there is a big difference between something organized and
21 thousands or millions of dollars and a bunch of "I can't read
22 exactly what this number is," so that's a mark. Can't read
23 this; that's a mark.

24 COMMISSIONER LAUFER: It's my understanding that the
25 investigations are funded by the fines, and they're basically,

1 you know, federally deputized bounty hunters, and you know,
2 I've got enough other stuff going on without somebody, like
3 that, coming in.

4 Fraud and abuse exists for sure, but a lot of it's in the
5 soft line of, you know, who is disabled? You know, I have a
6 patient who is a paraplegic, and I think I mentioned to Dr.
7 Hurlburt yesterday, he paid more taxes than I made last year.
8 You know, he is certainly able. And there other people who
9 it's hard to define why they're disabled who, somehow, are
10 disabled. It's very -- it's soft, and it's actually not my
11 call. I don't do disability ratings.

12 COMMISSIONER STINSON: The companies that perform these
13 investigations, they get a percentage of whatever they find
14 wrong. So if something is dotted wrong or if there is one
15 number that's off in a five-letter code or a six-letter code
16 or they can't make out what that fifth letter is, that's part
17 of what they're going to collect from the business. So this
18 is what turns off physicians to Medicare and Medicaid, and
19 actually is probably just as much or more of a turnoff from
20 Medicare than the reimbursement because, if they really want
21 to, they can throw you in jail. That's pretty harsh.

22 COMMISSIONER ERICKSON: So I've made the bullet that will
23 -- it sounds like there might be some agreement, at this point
24 -- we won't make the final decision now -- to include it on
25 our 2012 agenda.

1 CHAIR HURLBURT: Wes?

2 COMMISSIONER KELLER: Well, yeah (affirmative). All I
3 want to say is I really support that we do that, and I want to
4 tell you, from a legislative perspective, I don't disagree
5 with anything that has been said, but I want to throw in
6 another perspective. I get "whistleblowers" regularly, and
7 they are credible, and I would like to see us have to deal
8 with it here at the Commission with them sitting out there,
9 and so I think it would be a good vehicle for that.

10 And I think, you know, if I had to guess -- and I'm
11 guessing; I don't know this. If I had to guess, I think that
12 a lot of the legal -- the real issues -- I want to call it
13 legal fraud. In other words, this gray area is there. And
14 then when we try to enforce things that are gray, then the
15 people that are operating in good faith get beat up
16 ridiculously, you know, but that's just the kind of results we
17 get. But really need to do some work in this area.

18 COMMISSIONER ERICKSON: Val?

19 COMMISSIONER DAVIDSON: I love serving on the Health Care
20 Commission, some days more than others, but I would definitely
21 not appreciate being the adjudicator of those whistleblower
22 claims. I think that responsibility lies elsewhere. With all
23 due respect to your fabulous idea, I think I'm not really
24 interested in serving in that role.

25 COMMISSIONER ERICKSON: Okay. Back to payment

1 reform.....

2 COMMISSIONER DAVIDSON: And I'm sure everyone around the
3 table would have a conflict.

4 COMMISSIONER ERICKSON: Back to payment reform, any other
5 thoughts that you just want to get thrown down for now, for
6 our first very rough draft related to payment reform
7 recommendations? Val?

8 COMMISSIONER DAVIDSON: So there was a lot of
9 conversation about costs and then we talked a little bit about
10 value, but we didn't talk about the cost of delivery. So you
11 know, we talked about shipping supplies, in and out, and all
12 of those things that go with covering the cost of doing
13 business in Alaska. I think we shouldn't lose that piece.

14 CHAIR HURLBURT: Won't that kind of fall in with the
15 second portion of our Milliman report, where we've asked them
16 to do some work on getting at some of the drivers? They
17 presented us pricing information or claims information this
18 time. And then phase two should, hopefully, provide some
19 information that we can take and use to pursue that.

20 COMMISSIONER ERICKSON: Val, were you suggesting that our
21 recommendations related to payment reform, that payment reform
22 solutions should take into consideration the cost of
23 delivering health care in Alaska? Okay.

24 COMMISSIONER DAVIDSON: Because the payment -- the
25 revenue is only one side of the cost of doing business. I

1 mean, you can say \$5 is too much to pay for a toy or whatever
2 product it is, but if the price of providing that piece is
3 \$100, \$5 is pretty cheap.

4 COMMISSIONER LAUFER: I think it's a question I asked you
5 yesterday. If milk costs \$9 a gallon and fuel costs \$6.....

6 COMMISSIONER DAVIDSON: \$6.20.

7 COMMISSIONER LAUFER: \$6.20. How much do you have to pay
8 the plow guy to plow your parking lot? You don't have to do
9 that at all in Seattle. How much do you have to pay a guy to
10 stay or a doctor to stay in Bethel for more than their two
11 years of loan reimbursement, if their wife desperately wants
12 to live in Seattle? You know, that's why. What? Heated
13 sidewalks, yeah (affirmative), and there's great sushi and the
14 museum and my parents are there to help, blah-blah.

15 COMMISSIONER MORGAN: Like my example, and there are many
16 of them, when we were having those two dental labs brought up,
17 the cost of them transporting in the state of Washington,
18 anywhere in the state of Washington was \$1,100 to \$1,200, not
19 for -- just moving it, taking it from their warehouse to where
20 they're going to assemble it. It cost us -- and this is the
21 cost from Anchorage to Sand Point, not -- that was extra --
22 was almost a little over \$14,000. So even the cost of -- the
23 depreciated cost, which is computed into your Medicare and
24 Medicaid rates, if you're doing cost-based -- so if the cost
25 is a lot higher, then you are depreciating over the years and

1 replacement is a lot higher, and it's everything. It's
2 everything to do medical activities is a much higher cost in
3 rural Alaska, and it's because none of the people involved in
4 delivering it -- it's not their -- I mean, they have no
5 control over that. There is only one airline -- there was
6 only one company that could bring that stuff to Sand Point.
7 There weren't four. There weren't three. There weren't two,
8 but one. And they quoted a price, and if you didn't want
9 that, then I guess you could wait a year to get to the next
10 big cargo plane. But also getting stuff out, moving people
11 around, moving -- one of our large costs in the Aleutians was
12 medical waste. I mean, it was big enough that it wasn't
13 included into the utilities, like it is here. It was a
14 separate item because you can't just put that in the landfill,
15 from x-rays to all that other stuff. But as I understand it,
16 that will be segmented and shown in our study. So I don't
17 know if we necessarily need to just be cognizant of costs, but
18 our study is going to have that. If transportation utilities,
19 which are costs that are not in our -- it is in health care's
20 control because they buy it -- I think he'll segment it with
21 the other comparisons. I think he agreed to that yesterday;
22 didn't he, Deb? I mean, so it's in the study.

23 COMMISSIONER ERICKSON: Yeah (affirmative), but I think
24 Val was saying something different. Val?

25 COMMISSIONER DAVIDSON: No. My worry was that we're

1 talking about reform recommendations without having the full
2 picture. And so I just want -- as long as we're going to come
3 back to recommendations after we have the other half of the
4 picture, then I'm okay, but without having that cost piece of
5 it, it just seems premature to be jumping to recommendations,
6 unless we're going to come back to the recommendations after
7 we've also evaluated the other half of the equation.

8 COMMISSIONER ERICKSON: Jeff, you were starting to say
9 something a minute ago and then Noah?

10 COMMISSIONER LAUFER: Another thing just crossed my mind.
11 I'd love to focus on solutions where the money is spent in
12 Alaska, and I think that has, you know, obviously, political
13 appeal, but one of the obvious economic fixes for, like, the
14 payers is to ship them out and that is money collected from
15 employers in Alaska and spent elsewhere. And there is a real
16 reason to do that, but I'd rather see it circulate here a few
17 rounds before it goes anywhere else.

18 COMMISSIONER ERICKSON: Other thoughts related to payment
19 reform? Do you.....

20 CHAIR HURLBURT: We've got about 25 minutes left on this.

21 COMMISSIONER ERICKSON: Do you want to spend a little bit
22 of time talking about some of the topics from yesterday? I
23 could suggest one of them or I'll wait a minute. Is there a
24 particular topic from yesterday that.....

25 COMMISSIONER HIPPLER: Are you referring to the

1 recommendations that we discussed yesterday?

2 COMMISSIONER ERICKSON: No. I'm sorry, the learning
3 sessions we had after the recommendation discussion yesterday.
4 I don't want to go back and revisit the recommendations we
5 discussed yesterday. That's not what I meant, but just as an
6 example, we didn't spend time learning directly about price
7 and quality transparency, but there were readings in your
8 notebook related to that. The all payer claims database and
9 the hospital discharge database conversations yesterday and
10 the material in the notebook related to those are related to
11 price and quality transparency, in addition to tools to
12 support quality improvement. And Noah liked the article that
13 I included related to hospital pricing.

14 COMMISSIONER KELLER: I did have a thought yesterday. I
15 talked about it a little bit with Allen, that maybe we ought
16 to -- in the patient-centered home Findings and
17 Recommendation, that maybe we ought to have a transparency
18 bullet in there.

19 COMMISSIONER ERICKSON: We do have a separate strategy
20 for price and quality transparency. I mean, we could write a
21 whole separate section on price and quality transparency and
22 have recommendations specific to that.

23 COMMISSIONER KELLER: Okay. I was thinking that maybe
24 the tie to the patient-centered medical home might be
25 valuable, but maybe it isn't necessary. I just hadn't.....

1 COMMISSIONER CAMPBELL: In regard to this anti-trust
2 issue that came up a while ago -- I guess it came up yesterday
3 in one of the conversations about we might have to move to the
4 umbrella of the State's ability to overcome these kind of
5 hurdles, I have no idea, regulatorily, how that happens, but
6 it's something we probably ought to be cognizant of as we're
7 talking about this transparency stuff because we don't want to
8 get somebody down the road, you know, playing golf and talking
9 about these things and then get in trouble later on. So we
10 better find that out up front, how we should couch these
11 studies and conversations under the State's anti-trust
12 umbrella.

13 COMMISSIONER KELLER: Yeah (affirmative). I think, you
14 know, if you want, I can look into that, and I'm in danger of
15 saying more than I know, but the anti-trust laws, I think, are
16 very old in the books, and there is a lot of, what do I want
17 to say, traditional long-term standing, you know, laws that
18 we're talking about here. I mean, this wasn't a new law, and
19 I think that, you know, if we were going to look at any kind
20 of reform of that for the sake of health care reform, we might
21 have a challenge, but I will try to look into that. I'll put
22 some staff time on it.

23 COMMISSIONER HALL: Thank you. We talked yesterday about
24 whether or not voluntarily providing hospital discharge data
25 was adequate. I'm sitting here looking at the chart in states

1 that do have some kind of mandate. Is this valuable enough to
2 collect, apparently, the other 25%, that we would want to make
3 this a mandatory, recommend that it be mandatory?

4 COMMISSIONER CAMPBELL: Recognizing that mandatory is a
5 bad word, could we plant another semantical term, so we don't
6 all get brick bathes? But if you need the data, then you --
7 more data in this particular regard is probably better than
8 being 25% shy, even though it isn't from the smaller areas,
9 but it's major chunks of our rural areas to begin with. So I
10 guess I'd come down on the side of finding some, for what of a
11 better word, to encouragement for everybody to submit their
12 data because it's nothing to be ashamed of. It's just a
13 reminder that it can be costly for somebody to collect this
14 stuff and submit it in a common format that can be used. So I
15 guess I would have to come down on some sort of mandate or a
16 strong encouragement, at least, because, if you've got 25% of
17 your data missing, that could be important.

18 COMMISSIONER HIPPLER: A mandate to provide data is a
19 mandate to increase costs. We're either going to force the
20 medical providers to increase their fees to pay for this, or
21 if we make it a funded mandate through the State, we're
22 forcing all the citizens of the state of Alaska, even if, for
23 whatever reason, they don't use physicians, we're forcing them
24 all to pay for it.

25 COMMISSIONER CAMPBELL: That's absolutely true, but as a

1 former person who used to submit this data to a national
2 database -- and I had small statistics -- it mattered not to
3 the national scene or the state scene, but the feedback of
4 that data for me to educate, well, my staff and medical staff
5 about what they were doing was worth my personal time every
6 month to submit that data. And you know, well, I guess that
7 wasn't all that expensive, but it wasn't all that cheap
8 either. And in fact, I had other things to do, but the fact
9 is it was a cost. It is a cost, but if the information helps
10 you do a better job by knowing where you stand on this
11 continuum, whatever you're measuring, then that is valuable
12 and it's worth doing, in my mind, even though it is a cost.

13 COMMISSIONER HIPPLER: You found value in it. What if
14 other people don't? Are you going to force them to do
15 something that they see no value in?

16 COMMISSIONER CAMPBELL: Well, I suspect that there is
17 some nugget in all of this feedback through these people, and
18 I was one of the smaller providers in this state, and there
19 was some value to me. Even though it was particularly state
20 specific, there was other state data in it because other
21 people in the state did it, but I wasn't forced to it, of
22 course. But the fact was that I always found some use, and I
23 suspect every one of these people, if they could get into the
24 database without putting anything in, would find something
25 valuable to them in it. And it's just like anything else.

1 People, if they could ride along free, would do it. That's
2 human nature. And so I subscribe -- I come down on the side
3 that, if 25% of your data is missing, then you have got a
4 potential problem of knowing whether your answers are right or
5 wrong going down the road. So that's where I come down.

6 COMMISSIONER HALL: Thank you. I think my concern with
7 having this data is much of our conversation this morning and
8 -- I can't remember -- Professor Miller, and when he had
9 various diagrams, one of them measures that he was using as
10 one of the benefits was fewer hospitalizations, and if we can
11 capture that, it seems like this is a national database that
12 would allow us to capture that kind of measure fairly easily.
13 I would recognize it certainly costs anytime we collect data.
14 We're talking, at this point, what, 16 hospitals out of 27
15 that don't report, but it's those 16 that only represent 25%
16 of the information. But if we're going to look at payment
17 reform and try some of these models, that was one of the major
18 measurements, which is why I'm suggesting we might want to
19 look at this.

20 COMMISSIONER ERICKSON: And Denise, our presenter
21 yesterday -- actually, I don't know if you all noticed, she
22 was in the room with us all day yesterday and was here all
23 morning this morning, but then she had to leave to go catch a
24 plane, but she came up to me afterwards and she mentioned she
25 was particularly fascinated, of course, by the conversation

1 this morning related to data, and she mentioned that one of
2 the beauties of the hospital discharge database and the all
3 payer claims database is that it is a cheaper way. When you
4 consider the alternative to be to go to the individuals
5 providers, it's cheaper to aggregate that data from the
6 hospitals and the payers for the health care services than
7 mandating that all individual clinicians report, if you agree
8 that you need to have that data for quality improvement
9 purposes for measuring system improvement and for making
10 better health care decisions.

11 I'm not sure what Jeff thinks about the all payer claims
12 database, since he is the one who would be mandated. He is
13 the one representative of the industry that would be mandated
14 to participate along with the State, Dr. Hurlburt.

15 COMMISSIONER LAUFER: (Indiscernible - away from mic)
16 raise administrative costs.

17 COMMISSIONER DAVIS: There would, undoubtedly, be a
18 couple others who would be brought to the table around that,
19 but I don't have a great deal of concern about it. I think
20 the value would likely outweigh the cost of us participating,
21 and it's a source of some frustration and lots of work-arounds
22 not to have readily available data in Alaska. In Washington,
23 they have a mandatory hospital discharge database that we use
24 a lot just to have a better handle on where the money is being
25 spent, what the risk really looks like, where the

1 opportunities are, those sorts of things. So yeah
2 (affirmative), I would not oppose it. Now I'm not talking to
3 my CIO about that at the moment, but I would not oppose it.

4 I will add I believe, if you tried to go down that road
5 and it was voluntary, that it would likely not be worth the
6 effort because it would be incomplete. So I'm not speaking
7 for the hospitals, and Jeannie gave us some really good
8 reasons why a lot of them don't report and why she wasn't
9 going down the mandatory there, but I believe, on the carrier
10 side, it would have to be mandatory, at least to some level of
11 premium. You could probably draw a line, as Denise suggested,
12 because, if it wasn't mandatory, I suspect others who have a
13 more national view would decide not to participate. Linda
14 would need some teeth to make that happen. The Division of
15 Insurance would need some teeth to make that happen. Linda
16 has teeth.

17 COMMISSIONER HALL: I have teeth.

18 COMMISSIONER DAVIS: They're your own; right. Well, I'm
19 an 800-pound gorilla, so.....

20 COMMISSIONER CAMPBELL: Well anyway, I know, from my
21 years of chairing the Blue Cross board, the actuaries would
22 give you a less definitive answer because of the data holes,
23 and they're very conservative. And when they don't have data
24 to go by, my experience is that they're less willing to give
25 you as firm an answer as they could, as if they had a complete

1 set. I do know that.

2 COMMISSIONER ERICKSON: What about price and quality
3 transparency for the consumer? We haven't really -- it was
4 touched on a few times, but we haven't really talked about
5 that. And I'm remembering that that's why price and quality
6 transparency ended up on our strategy list in the first place.
7 We were really talking about consumerism.

8 COMMISSIONER DAVIS: This is Jeff Davis. As I read
9 through the pre-read materials -- do I get a gold star this
10 time for that? A well-timed flight to Seattle that allowed
11 for that, but as I read through it, particularly price and
12 quality transparency, it was -- there was a theme there that
13 could be characterized as this is really hard work, even
14 though we're working hard at it, and it is -- my experience,
15 to date, is it's difficult to get to, again, meaningful
16 information.

17 I think it, in some ways, may parallel the discussion
18 we've had about payment reform in that it needs to happen, but
19 it's probably going to take a long time to get where we want
20 to get, and it -- we probably need to look to where we can be
21 successful initially, but it is one side of this equation that
22 is a major gap and causes us not to make the decisions we want
23 to make. I mean, people who do have a motivation to shop for
24 care based on cost and quality, it's really, really difficult
25 to get that information, as we heard from Jeff Ranf yesterday.

1 When Dr. Laufer or Dr. Stinson wants to make a referral for
2 something to someone else, they, I believe, do not have the
3 tools they need to make the decisions, and Noah and I were
4 talking about an example where there was a ten-fold difference
5 in costs between referring to one provider and referring to
6 another, and nobody knew that, except I happened to know it
7 because my wife had gone to that provider. So you know,
8 otherwise, I wouldn't have known it either. So it is
9 something that, I think, is a big body of work that needs to
10 be addressed, but it's going to be a difficult road.

11 COMMISSIONER ERICKSON: I was just remembering the one
12 slide that Harold Miller put up today that showed the scenario
13 with three different providers with quality information about
14 those, but the fact -- or quality information is lacking. The
15 way that consumer-driven health plans work right now with all
16 of the payment up front rather than on the back end, the
17 patient is going to pay the same amount regardless of which
18 provider he or she would go to. They're going to end up
19 paying \$7,000, regardless of whether they go to a \$23,000
20 provider compared to a \$33,000 provider, and I think that's
21 one of the things that we read in the materials that I
22 provided that one of the dangers of transparency, price
23 transparency specifically and especially without quality, is
24 the patients might tend to make the assumption that higher
25 price means better value. And even in consumer-driven health

1 plans, even with a high deductible and co-pay, in the end,
2 they're going to pay the same amount. Is there some other way
3 that we need to be thinking about both protecting against
4 consumers, understanding the difference between price and
5 value, and then also talking about designing benefits in a
6 different way?

7 COMMISSIONER DAVIS: Deb, those are all really good
8 points, which is why this is such a difficult subject, and it
9 makes sense, you know, intuitively, that, if people have
10 better cost and quality information, they could make better
11 decisions, but what happens in health care is that there are
12 other factors that often come into it that make the
13 interpretation. It's kind of like the caveat in the Milliman
14 study about you need to be an actuary to really understand the
15 data and make a decision from it. So we have to.....

16 UNIDENTIFIED MALE: (Indiscernible - away from mic)
17 newspaper?

18 COMMISSIONER DAVIS: In the newspaper. So what I'm
19 saying about let's find the things that work is, you know,
20 there are probably some measures that can be used and looked
21 at that people can -- that are pretty solid, people can make
22 conclusions from, but it's going to have to take a careful
23 search to find those.

24 On the benefit side, again as you pointed out and as was
25 pointed out in the articles, it's true that, in most plans,

1 even high deductible plans, people, if they have something
2 serious, they go through their out-of-pocket max and then
3 they're paid at 100%. Their bills are paid at 100% under the
4 contract, and they really don't have a financial incentive any
5 longer. So to get around that, yeah (affirmative), you do
6 have to look at different benefit solutions, and it's a very
7 salient point because what we've found working on this for
8 years is that what consumers care about is the cost to them.
9 So they want to look and see what's my -- you know, what's it
10 going to cost for me to go here and what's it going to cost to
11 go there? Well, I can go to Provider A and it costs me the
12 same as Provider B, just the same example that Harold gave.
13 They will then -- now it is no longer a decision point.

14 And there was another point I was going to make. Sorry.
15 Fatigue setting in here. Yeah (affirmative). Sorry. I lost
16 it.

17 COMMISSIONER ERICKSON: Linda?

18 COMMISSIONER HALL: Well, it's not really what we're
19 talking about in terms of costs for consumers currently, and
20 in Alaska, it will be January 1st. Under federal law, health
21 care premiums are going to become much more public and the
22 rationale for those, and they will be posted on a federal
23 website. They will be posted on the Division of Insurance
24 website. So there will be a lot more information for
25 consumers about insurance premiums.

1 There will be -- we will be posting common definitions
2 that have been developed by regulators nationally for
3 consumers to read about what does the term co-insurance mean,
4 what does -- you know, all of the terminology that you find in
5 insurance policies that I would call the insurance-ease.
6 There has been about six months worth of work by a committee,
7 which I was not on. I was smart enough not to do that, but
8 they have come up with common definitions, examples. There
9 really is an attempt to help make health insurance more
10 understandable for consumers. While it's not what you're
11 talking about, price and quality, I think it's a start for
12 education and common terminology that will be used in policies
13 that will be used nationally. Every state will have these
14 same terms on their website and the ability for consumers to
15 find that. So I mean, I think there are things happening that
16 are transparent and that will provide some assistance.

17 COMMISSIONER LAUFER: This is such a complex issue that's
18 been going on forever. I think my concern would be the
19 unintended consequences of anything you put up. You know,
20 measuring quality is an obvious area of, you know, potential
21 disaster. You know, the simplest thing would be to have open
22 websites where patients rate their experience because, you
23 know, as an employer, I would buy insurance. I'm thinking,
24 God, you know, how do I avoid an 18% increase this year?
25 What's cheaper? And if I ask the vendor, well, what do I get,

1 what's covered, what oncologists can we see, what experimental
2 drugs or non-experimental drugs are covered, you know, all the
3 details, they're not able to tell me, and they're free to
4 change. You know, it's a moving target. So all I'm doing is
5 kind of paying protection money in the hopes that we won't go
6 bankrupt.

7 And when you're really sick, and you know, trouble is
8 there, you're an instant minority without the capacity to
9 understand what's going on or the barrage of paperwork or the
10 bills, and the bills don't come in one at a time. They come
11 in this, that, trickle in, another \$10,000 for that, 12 for
12 that. What was that? I never even met that person. And you
13 know, you're a minority without the energy, or you know,
14 emotional or physical to cope with it and that's what really
15 needs to be measured. You know, Tier I, they used to be
16 Premera patients. Now they're Wells Fargo patients as far as
17 payers. Are they happy with that? Are the individual
18 recipients, are they happy with that change, and not just in
19 the first year when everything is really nice, you know, but
20 in the long run? You know, how do you measure that? That's
21 really the question or do you feel that you were adequately
22 and fairly covered? Not when you buy it, but with the actual
23 product because it really isn't free market economics. When
24 you're sick, you know, I need whatever works. There is a
25 chance that this chemotherapy drug is going to work. Yeah

1 (affirmative), and the decisions aren't made by the consumer
2 of it. They're not really made by the doctor, who often
3 doesn't even know what it costs. You know, they're all sort
4 of arbitrary. There are too many non-free market factors.
5 You know, how would you guys like to have a feedback rating
6 from members of Premera that was available to people, like me,
7 looking to buy insurance?

8 COMMISSIONER DAVIS: So I think it would be great,
9 actually. One of my colleagues had an idea, which I thought
10 was interesting. It's sort of a Wikipedia type -- and this is
11 something that actually the State could look, but you know,
12 all of this is fraught with danger, but in Wikipedia, people,
13 you know, are free to put in -- add to the definition. Well,
14 what if there was a Wikipedia for health insurers and health
15 care providers, and you know, it was sponsored by the Division
16 of Insurance, right, Linda, and you know, managed by it and
17 people could go and look and see what their experience was? I
18 think that could be, you know, useful dialogue. Now how is
19 that about quality? It's probably more, you know, about
20 consumer experience than it is about quality, but that could
21 be interesting.

22 But if I may, I'd like to tell a quick story that
23 illustrates the foibles of this. This is a 25-year old story,
24 but it still applies, which tells you how much progress we've
25 made.

1 There used to be this company called Eastman Kodak.
2 Anybody remember that company? They used to be really huge
3 because people had cameras that took film. They
4 (indiscernible - voice lowered) pictures. You took film, and
5 they did stuff. Anyway, they were concerned about what they
6 were paying for health care costs back in 1986, and they were
7 big enough that they had a population that was credible and
8 they could hire the people to do the analysis, and their
9 thought was that they were going to find physicians that had
10 the highest cost -- or the most efficient practices in terms
11 of cost and quality and they were going to steer their
12 patients, their members towards those physicians, and they
13 went through all this, you know, years' long analysis and kept
14 coming to dead ends, dead ends, dead ends.

15 Finally, they found -- they thought they were on to
16 something. They found two physicians who lived in the same
17 town, had gone to the same medical school, same residency,
18 same specialty, and one of them had cost -- if I remember
19 right, it was three times higher than the other. And so they
20 thought, ha, you know, we can -- we'll send him to the guy
21 with the costs -- both were men -- you know, that's one-third,
22 but let's go talk to them first and find out what -- how he
23 does it, what his secret is. So they went and they talked to
24 this physician, and he said, you know, I'm pretty good at what
25 I do, but my buddy from medical school, he is absolutely the

1 best, and when I have a really complicated case, I send it
2 over to him and that was the end of the project. They shut it
3 down because how is a consumer ever going to know that?
4 They're never going to know that. So that's the difficulty.
5 Does that mean, because we can't have a perfect solution, we
6 don't go for good solutions? No. I think we have to try, but
7 it is a difficult road.

8 COMMISSIONER ERICKSON: We need to move to the next point
9 on our agenda. So Wes, you'll be our final commenter on this
10 part of our agenda.

11 COMMISSIONER KELLER: I probably should pass, but I can't
12 resist. When I buy insurance for my car as a consumer, it's
13 very simplistic compared to health care. I understand that,
14 but it's really the same thing. I'm betting the insurance
15 company -- let's say I just have collision on my car. I'm
16 betting the insurance company I'm going to crash my car, and
17 they're betting I'm not, you know. And so that's where your
18 actuarials and all the data comes in here.

19 I think the biggest disservice that we've had is when CMS
20 -- and it's just a natural -- I mean, a lot of providers just
21 call Medicaid insurance. That's not fair. That's not right.
22 There is nothing there, you know, having to do with a consumer
23 element. In that case, I'm hoping that the government,
24 whatever it is -- when I'm talking about a government payer,
25 I'm hoping that they're going to come through and cover me.

1 Yeah (affirmative), that gives me some kind of assurance that
2 I'm going to be going to be taken care of, but there is
3 nothing that I'm buying there at that level at all.

4 So to me, you know, for what it's worth, it is more a
5 comment. Just -- you know, this is where you pull my chain
6 and I get going, but the -- it's really a disservice that --
7 in fact, I got in the Panel when they were talking because
8 they just equated Medicaid with insurance, and CMS does that,
9 you know. In fact, that's one of their bullets. They say hey
10 now, Medicaid is insurance now, you know. And so you go to
11 *Merriam-Webster's* right now and look it up. You'll see that
12 what we have in Medicaid is not insurance, just not in the
13 traditional sense of the word, you know. So the confusion --
14 like Noah just said, the confusion for the consumer is just,
15 you know, obscene. It's huge.

16 COMMISSIONER LAUFER: It was assurance. Initially, I
17 think that was the terminology. And the difference, if you
18 insure someone, we'll cover you while you probably aren't
19 going to get sick. Assurance is we're going to make sure you
20 don't suffer too much while you are sick and die and that's a
21 whole different game, but that's why this whole narrative
22 approach to medicine makes sense. We don't -- nobody lives
23 forever, and how do you do that with nobility, with, you know,
24 a nice narrative to your life with minimal pain, experiencing
25 compassion without, you know, dying in poverty and misery and

1 pain alone?

2 COMMISSIONER ERICKSON: Well, thank you all very much.
3 That was a good conversation and helpful. I've captured lots
4 of ideas. What I'm going to do is -- I may or may not clean
5 it up. Would you want to see this slides right away? I could
6 go ahead and -- no. I see heads shaking. So what I'm going
7 to do is what we did the last time.

8 I'm going to take a stab at drafting some Findings and
9 Recommendation statements based on this conversation, and
10 we'll schedule a one-hour follow-up teleconference to work
11 together over the phone on refining those somewhat in advance
12 of our October meeting.

13 Then at our October meeting, our plan, again, is to have
14 an in-person report by the Milliman consultants, and we'll
15 have the second part, the second phase of the study in draft
16 form at that point. So this will be another opportunity to
17 provide some feedback to them before the reports will be
18 finalized in November.

19 And you all had invited the long-term care group that
20 presented, just was intended to be an informational
21 presentation, but had asked them to come back and make some
22 recommendations to (indiscernible - voice lowered) about what
23 you should recommend related to long-term care. And so right
24 now, they're planning on doing that. They were meeting. I
25 don't know if you remember they looked a little bit like deer-

1 in-the-headlights when you asked them to do that because they
2 didn't think they were going to be able to come up with
3 something quite so -- they were on a timeline that was going
4 to take them into next spring, but I believe they're still
5 planning -- they know they're on the agenda anyway, whether
6 it's just making them breathe harder as we get closer or not
7 and how prepared they feel. I know they're planning on being
8 here. So I'm making time for them on the agenda.

9 Workforce is one of our infrastructure components. There
10 is the Alaska Health Care Workforce Coalition that's
11 continuing to meet, and they're working on an action plan for
12 implementing the comprehensive plan they developed last year
13 and that is to be finalized over the next month, and they're
14 planning on being here at the October meeting to present that
15 to you. Yes, David?

16 COMMISSIONER MORGAN: The House is having a hearing on
17 House Bill 78 and the Loan Repayment Program. It's the first
18 day of the Primary Care Fall Conference. I think it's either
19 the 13th or.....

20 COMMISSIONER ERICKSON: It's September 14th.

21 COMMISSIONER MORGAN:14th, just the same day as the
22 Tri-State Children. But anyway, it would behoove some of us
23 maybe to go to that, just to hear what testimony -- or give
24 testimony or listen to testimony. Is that your committee?

25 COMMISSIONER KELLER: No. I think it's the Senate.

1 COMMISSIONER ERICKSON: Yeah (affirmative), the Senate.
2 So in addition -- so we'll have those three presentations, but
3 the majority of the meeting -- those won't be quite as long,
4 except maybe the Milliman we'll allow enough time for. The
5 other two will be shorter, and we'll spend the rest of the
6 meeting finalizing in draft form Findings and Recommendations
7 and also our plans for the 2012 Commission Agenda in
8 anticipation of releasing those to the public for public
9 comment for the month of November. And then we meet again
10 December 9th for just one day, the way we've done now the past
11 couple of years, to consider public comment and finalize our
12 report for the Legislature and the Governor.

13 And I threw down just a few things, just to plant the
14 seed for thinking in advance for next time about the things
15 that I think I've been hearing over the past year or two,
16 where we might be going next for 2012. We'll keep our
17 standing agenda items, information and update related to the
18 Health Information Infrastructure, Workforce Development, and
19 continuing to learn about how previous recommendations are
20 being implemented.

21 But some of the parking issues, I've categorized these a
22 little bit by looking at some innovations and shifting
23 paradigms where we're looking at policy strategies for really
24 doing things in a different way more fundamentally, and those
25 include, just because we haven't done it before, indicators

1 for measuring statewide health care delivery system
2 improvement. We brought that up earlier.

3 Things that we've talked about before are the employer's
4 role in health and health care, the employer's role in health
5 related to worksite wellness programs, and in health care
6 related to employee health insurance benefit design. We've
7 talked about that in the past, but we haven't really studied
8 it in any detail and developed recommendations related to it.

9 More tools and strategies related to shared decision-
10 making, end of life care, and genetics.

11 And then some other policy areas that have come up and
12 are in our parking lot, malpractice reform, fraud, and waste
13 and abuse prevention, and rural sanitation. So those are
14 things that I've been trying to -- I've been keeping in the
15 parking lot as I hear issues come up. So if you want to be
16 thinking about those and thinking about anything else that you
17 think is important, we'll talking about that in October.

18 Just really quickly -- yes, Val?

19 COMMISSIONER DAVIDSON: Can you go back to the prior
20 slide, the one that was about standing issues for meetings,
21 because I thought, about three meetings ago -- and I don't
22 remember it getting shot down -- I made a request for a report
23 at every meeting about where Alaska is with regard to
24 Affordable Care Act implementation. So for example, what's
25 our plan for exchanges? What's our plan for -- I know, at one

1 meeting, we had this fabulous report of grants that the State
2 had applied for, and it just seems like -- when we're tasked
3 with the future of our health delivery model in Alaska, to do
4 that without any reference to where we are in terms of
5 Affordable Care Act implementation as a state, it just seems
6 like we're sort of preparing for a health care model on Mars
7 without sort of any indication of what our environmental
8 situation may be. And I think that -- you know, I realize
9 that maybe not much information can be shared, but something
10 is happening with Affordable Care Act implementation. I'm
11 hearing rumors that we are going to have an exchange, that
12 we're not going to have an exchange, we're going to have a
13 federal exchange, we're going to have state exchange, but
14 there are questions that I get asked every single day. And I
15 think we need to have, at every single meeting, some report
16 from the Commissioner's office or the Governor's office or
17 wherever those decisions are being made about what's
18 happening, what is the status quo, and what are we -- how is
19 that impacting our work here, and it keeps falling off the
20 agenda somehow. So I don't know if I need to make a formal
21 motion or.....

22 COMMISSIONER ERICKSON: Let's save it for a formal motion
23 for when we work on the 2012 draft agenda in October.

24 COMMISSIONER DAVIDSON: Well, I thought I made a formal
25 motion three meetings ago. So I'm happy to make another

1 motion again. So I would move that, on the standing agenda
2 items starting next meeting, we have a report from the office
3 of the Commissioner or the office of the Governor about our
4 status of Affordable Care Act implementation, and certainly
5 with regard to exchanges.

6 COMMISSIONER HIPPLER: Second, with a caveat that that be
7 a request to them.

8 COMMISSIONER ERICKSON: Okay. So I just want to clarify.
9 We did not vote on it in the past. So I need a minute. Let
10 me do it.

11 COMMISSIONER DAVIDSON: So I was asked a question, who is
12 going to provide it? It's whomever has that responsibility,
13 whether the Commissioner's office is working on it or whether
14 the Governor's office is working on it. I'm not sure where,
15 but somehow.

16 COMMISSIONER KELLER: I've got to -- that presumes --
17 that motion presumes that we are implementing PPACA. We are
18 in court, okay? So I would reword that to say an update of
19 where we're at with PPACA and not say with implementation. In
20 other words, yeah (affirmative), I want to hear what's going
21 on, on the lawsuit and everything else, but I don't want the
22 Health Commission to be making a statement that we're
23 presuming that the state of Alaska is in the mode of
24 implementation.

25 COMMISSIONER DAVIDSON: I guess I'm not looking for a

1 presentation from Department of Law because, I mean, I
2 certainly am aware of what the status of the litigation is,
3 and I'm not -- what I don't want is to have a panel of lawyers
4 who are talking to us about Affordable Care Act and whether
5 it's constitutional or not. I want to know, based upon
6 whatever it is that either the Commissioner or the Governor is
7 hearing from those folks, how are they reacting and how is
8 that impacting us here.

9 So for example, if the litigation goes forward and the
10 state of Alaska and whomever is opposed to it wins, then what
11 does that mean for Alaska with regard to exchanges or an
12 individual mandate, or I mean, all of those kinds of things
13 because I think somewhere, somehow that is impacting us, and
14 right now, our position has been -- it seems to be our
15 position has been, we won't have to deal with it until the
16 court decides, and I think that's a mistake.

17 COMMISSIONER KELLER: Yeah (affirmative). I think the
18 briefing is a good idea, Val. I really do. I was just
19 talking about the wording.

20 COMMISSIONER ERICKSON: The way we word it.....

21 COMMISSIONER KELLER: I don't want to be sending a
22 statement of advocacy here.

23 COMMISSIONER ERICKSON: David?

24 COMMISSIONER MORGAN: Well, I guess it's more of a
25 friendly amendment, I guess, maybe. Maybe when we did have an

1 update from the Commissioner's office, it was basically three
2 separate reports. One basically took all of the things that
3 the State was supposed to do with the timelines. Some were
4 required, some were optional, and then there was a gray one,
5 which we have been talking about, and it had timelines of what
6 was going on and who was doing what. Then there was another
7 one that basically was in blocks, giving more detail of sort
8 of what's happening, like on the public health stuff and this
9 and that.

10 I think, instead of wording it as a required report,
11 maybe, following that exact same template, that those are
12 provided to the Commission, and they should give us an update
13 on where they are on the Affordability Act, and it even had --
14 one of the reports had, you know, this is our plan for doing
15 these that are required. Here is our plan for those that are
16 optional, and these are the ones we picked and why. And then
17 there were some that we're just not going to do for whatever
18 reason, and this is why.

19 Why don't they just take the same template they did they
20 did the last time and just update it quarterly or something,
21 you know, or for each of our meetings and just provide that?
22 And if somebody wants to come along and give some explanation,
23 we would love to have them. I don't particularly -- I'm with
24 Val. I don't want 16 lawyers at the end of the table, but you
25 know, a Commissioner, Deputy Commissioner, or somebody that

1 could answer any questions because I know there is some
2 committee, or Division Head of Insurance, I think, was
3 actually on an internal committee.....

4 COMMISSIONER ERICKSON: That committee was disbanded.

5 COMMISSIONER MORGAN: Oh, it is? But how about if we
6 approach it that way, instead of specifically saying we want
7 to know about X or Y, but just give an update, just like you
8 did on the last -- you know -- you remember that template
9 we.....

10 COMMISSIONER ERICKSON: I remember. Val?

11 COMMISSIONER DAVIDSON: So I want to be clear about what
12 it is that I'm asking for. I want the information, and I also
13 want it as an agenda item, so that we actually have the
14 conversation about what that means in terms of shaping our
15 whatever is that our recommendations are. I think that
16 providing the information and having it in the packet -- we
17 got fabulous information at this meeting.

18 The real impact to the State is the conversation that
19 happens after we have that information. Getting the
20 information is really helpful. It's pretty handy, and it's
21 pretty darn snappy, but if we don't have it as an agenda item,
22 we miss that opportunity for conversation and dialogue that, I
23 think, really is the point of why we're here. So yes, I want
24 the information, but I also want it as an agenda item.

25 CHAIR HURLBURT: I think, as Wes's suggested, we can

1 provide an update on any activities related to the patient --
2 PPACA law. The Governor and the Attorney General have made
3 their determination it's an unconstitutional act and that's
4 the determination of this state. Individually, we may or may
5 not agree with that. I think, if we insert ourselves into
6 that legal hassle, we will undermine the potential that this
7 group has to achieve some good things.

8 We did have a wonderful meeting this time. We had some
9 good information presented, but I don't think our role is to
10 advocate for or against a determination that the Governor and
11 the Attorney General have made, although we will have
12 individual opinions on that.

13 COMMISSIONER DAVIDSON: That's not what I'm asking for.
14 I'm asking for, as things move forward, what are doing in
15 response to those positions as they change? I'm not asking
16 for advocacy. I don't really care, around the table, whether
17 somebody thinks the Affordable Care Act is the greatest thing
18 since sliced bread.....

19 CHAIR HURLBURT: And some people do. Yeah (affirmative).

20 COMMISSIONER DAVIDSON:or whether some people think
21 that it's the worst possible thing that has ever been created
22 in mankind.

23 The issue is, whatever the outcome, how are we going to
24 manage that information as we move forward? And somebody is
25 having that conversation, and I think we shouldn't pretend

1 that that doesn't have an impact on our role and our
2 responsibility.

3 CHAIR HURLBURT: Noah?

4 COMMISSIONER LAUFER: I think we do need an update. How
5 much could we ask for? Could we ask, how's it going in court?
6 That seems reasonable, but if you say we have a contingency
7 for it's determined unconstitutional, the whole thing falls
8 apart, and we have one for if it continues, and the more
9 likely one, that it just does this weird evolution for the
10 next 20 years, is having a report on that too much of a
11 political statement?

12 COMMISSIONER KELLER: If you're asking me, I think a
13 request for information from either the Department of Law or
14 Health and Social Services is fine. I'm.....

15 COMMISSIONER LAUFER: (Indiscernible - simultaneous
16 speaking)

17 COMMISSIONER KELLER: Yeah (affirmative), you know, and
18 that's -- if it's couched that way, you know, sure.

19 COMMISSIONER LAUFER: Could we get information on what
20 has been done up until that date as far as the State's
21 complying with the mandatory parts of the law? Is that -- you
22 know, it starts to.....

23 COMMISSIONER KELLER: Yeah (affirmative), I.....

24 COMMISSIONER LAUFER: Because we're doing some of that
25 already, I would imagine.

1 COMMISSIONER KELLER: (Indiscernible - simultaneous
2 speaking)

3 COMMISSIONER LAUFER: How about if we just sit quietly
4 and listen to whatever they tell us?

5 COMMISSIONER MORGAN: What I'm saying is, if you remember
6 the Commissioner and a couple other people came, and I thought
7 they were pretty cool. There was a spreadsheet that had every
8 provision that fell on the State from the Affordability -- and
9 it was 200 and -- it was over 200, and it had a grid of what
10 we have to do, what we -- and that was great. And then he had
11 another report that dealt with, like, this issue, like what
12 are we doing, what the update is, and where we are. It seems,
13 to me, the natural request would be take that template, just
14 update it for the next meeting, and then somebody show up, and
15 if we've got a question, we'll ask them.

16 COMMISSIONER STINSON: (Indiscernible - away from mic)
17 If we're making decision that affect the State, we ought to
18 know under what parameters we're making those decisions.

19 COMMISSIONER ERICKSON: So if it's for informational
20 purposes, I just want to clarify. If the purpose is to add to
21 the Commission's agenda strategies that are being implemented
22 by the federal government under the Affordable Care Act to the
23 Commission's agenda, we have the opportunity to do that for
24 this year -- and to the extent, we did -- I mean, we didn't
25 talk about it. It was on this list, and I said several times,

1 does anybody want to include the Health Insurance Exchange,
2 and then we came back the next meeting, does anybody want to
3 include Medicaid expansion under our Access Improvement
4 strategy, and nobody said a word, and we talked about it a few
5 times.

6 COMMISSIONER DAVIDSON: It's never too late to make the
7 right decision.

8 COMMISSIONER ERICKSON: I'm just suggesting -- what I'm
9 suggesting is, if you want to include an Affordable Care Act -
10 - and it wouldn't be about the Affordable Care Act. It would
11 be about, do we need a Health Insurance Exchange in Alaska and
12 what should it look like as a strategy? We could have that --
13 we could put that on the agenda for 2012. So what I'm
14 suggesting is, if that's what you want to do, you have another
15 opportunity to do that for our 2012 agenda.

16 COMMISSIONER DAVIDSON: Well then, we'll take it in both
17 places is my suggestion.

18 COMMISSIONER ERICKSON: Okay.

19 COMMISSIONER KELLER: I think, too, the information they
20 give us, you know, that they have -- it's public information
21 that they're going to give us. They're not going to give us
22 any confidential stuff out of the courts, but that will enable
23 us to make those kind of decisions about whether we want to
24 address the Health Exchange, or you know -- so you know,
25 that's fine.

1 If I could, Dave mentioned the HB78 hearing. I just
2 wanted to clarify that's the House Finance Committee, and it's
3 September 14. No. I had to look it up. I didn't know.
4 September 14th. It's been through my committee already. Yeah
5 (affirmative), and it's September 14th at noon at Millennium
6 Anchorage Hotel, 4800 Spenard Road. That's the one on
7 incentives for certain medical providers, you know, to entice
8 them to Alaska.

9 COMMISSIONER DAVIS: What time was that, Wes?

10 COMMISSIONER KELLER: Noon.

11 COMMISSIONER ERICKSON: So Val, I did not capture your
12 exact wording, but as we've had the conversation, there has
13 been clarification. I took a stab at drafting a motion for
14 you. Is this what you want to.....

15 (Pause)

16 COMMISSIONER ERICKSON: Is that what you said,
17 essentially?

18 (Pause)

19 COMMISSIONER DAVIDSON: (Indiscernible - away from mic)

20 COMMISSIONER ERICKSON: Are you okay with that Allen, as
21 the second?

22 COMMISSIONER HIPPLER: Yes.

23 COMMISSIONER ERICKSON: Any further discussion?

24 COMMISSIONER MORGAN: This is Dave Morgan. Just
25 encourage them to use the template that they used the first

1 time. I think that gives us what we need to know and where
2 they are, and they won't have to reinvent another report
3 format. They can just update that, if that's convenient, I
4 guess. (Indiscernible - simultaneous speaking)

5 COMMISSIONER ERICKSON: I think that's getting too
6 operational for them. I don't think we should dictate to them
7 what they should do.

8 COMMISSIONER MORGAN: Sure.

9 COMMISSIONER ERICKSON: I don't know that they have staff
10 available to do that.

11 COMMISSIONER MORGAN: Okay. Okay. I just thought it
12 was.....

13 COMMISSIONER ERICKSON: We could -- I mean, we have it on
14 our website. We can bring it.

15 COMMISSIONER MORGAN: Yeah (affirmative). It's just.....

16 COMMISSIONER ERICKSON: The old one. I don't know that
17 they would be able to update it.

18 COMMISSIONER MORGAN: Yeah (affirmative). Well, it's
19 just cool. I just thought it was a good format. It gave
20 everything you wanted to know of everything that was
21 happening, and.....

22 COMMISSIONER ERICKSON: It was cool. It was fabulous.
23 Thank you. Okay. People want to go home. We've gone over
24 time now. So -- and I think we're pretty done for all intents
25 and purposes, but now we need to call for the question.

1 So all in favor of the motion signified by -- oh, no.
2 You know what? For votes, now that we're real in law, we need
3 to go around the table and make sure we know who is yes and
4 who is no. I think I will ask for a show of hands, and if
5 it's not unanimous, then we'll.....

6 (Pause)

7 COMMISSIONER ERICKSON: Well, you two can't vote. You
8 two can't vote.

9 (Pause - background noise)

10 COMMISSIONER ERICKSON: Okay. It's not unanimous. Dr.
11 Hurlburt's hand is not up. So is your hand up, Allen?

12 COMMISSIONER HIPPLER: Yeah (affirmative).

13 COMMISSIONER ERICKSON: So I am seeing all voting
14 members' hands up, and for the record, the voting members --
15 except for Dr. Hurlburt's. So for the record, the voting
16 members in the room are Jeff, Noah, Allen, Emily, Val, Keith,
17 Larry, David voting yes, and all opposed? Abstaining? I'm
18 looking at the -- and Dr. Hurlburt is abstaining from the
19 vote. So the motion carries.

20 Any final questions or comments from the group before we
21 adjourn? And then I'll give Dr. Hurlburt, as the Chair, the
22 final word, for the good of the order.

23 CHAIR HURLBURT: Just a quick feedback. As I said, Deb
24 worked hard to try to build more discussion time in. I think
25 we, clearly, had more than we've had in other meetings. Did

1 that work?

2 COMMISSIONER STINSON: (Indiscernible - away from mic)

3 CHAIR HURLBURT: Yeah (affirmative). Any other comments?

4 How about this location, is it okay?

5 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

6 Those of us who have shorter legs need booster seats.....

7 CHAIR HURLBURT: Anything else?

8 COMMISSIONER ERICKSON:or shorter bodies.

9 CHAIR HURLBURT: Okay. So I thank everybody very much.

10 1:15:18

11 (Off record)

12 **END OF PROCEEDINGS**

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TRANSCRIBER'S CERTIFICATE

I, Lara Jury, CSR No. 1514, hereby certify that the foregoing pages numbered 2 through 443 are a true, accurate and complete transcript of proceedings in Alaska Health Care Commission Meeting held on Thursday, August 25, 2011, and Friday, August 26, 2011, at the Frontier Building, Rooms 890-896, 3601 "C" Street, in Anchorage, Alaska, as transcribed by me from a copy of the electronic digital sound recording to the best of my knowledge and ability.

September 27, 2011



Lara Jury, CSR No 1514