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ALASKA HEALTH CARE COMMISSION

TUESDAY, OCTOBER 11, 2011

8:02 A.M.

FRONTIER BUILDING, ROOM 896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 1 OF 2

PAGES 1 THROUGH 276

1 Ward? You're welcome.

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

4 COMMISSIONER KELLER: Representative Wes Keller.

5 COMMISSIONER DAVIDSON: (Indiscernible - speaking Native
6 tongue), Valerie Davidson representing tribal health.

7 COMMISSIONER CAMPBELL: Keith Campbell. I hold the
8 consumer seat on this Commission. Thank you.

9 CHAIR HURLBURT: Pat, can we skip over to you?

10 COMMISSIONER BRANCO: Patrick Branco, the Alaska State
11 Hospital and Nursing Home Association representative.

12 COMMISSIONER ENNIS: Emily Ennis. I'm representing the
13 Alaska Mental Health Trust.

14 COMMISSIONER HIPPLER: Allen Hippler, State Chamber of
15 Commerce.

16 COMMISSIONER FRIEDRICHS: Paul Friedrichs representing
17 the VA and the federal health care system.

18 COMMISSIONER LAUFER: I'm Noah Laufer, a family doc here
19 in Anchorage in private practice.

20 COMMISSIONER ERICKSON: Deb Erickson, staff to the
21 Commission.

22 CHAIR HURLBURT: Sarah, can we go with you and then we'll
23 go around the room?

24 SARAH (LAST NAME UNKNOWN): (Indiscernible - away from
25 mic)

1 (Pause - away from mic)

2 CHAIR HURLBURT: If you folks over here -- you are
3 critical to our session. If you could just introduce
4 yourselves?

5 (Pause - away from mic)

6 CHAIR HURLBURT: And Jeff Davis is coming in, the CEO of
7 Premera and member of the Health Care Commission here. So I'd
8 like to welcome everybody. Appreciate your coming.
9 Appreciate your interest. Deb, do you have anything you would
10 like to say to start?

11 COMMISSIONER ERICKSON: Just a few quick business items.
12 For everybody in the room, please help yourself to coffee and
13 breakfast, including the audience, please, if you haven't
14 already. Also we have handouts in the back of the room for
15 folks in the room. For folks online, all of the presentations
16 and handouts are posted on the Commission's website on the
17 October 2011 meeting page, except I did want to make a note
18 for folks on the phone that you will not have available to you
19 the first PowerPoint presentation this morning by Milliman.
20 You'll just have to follow along and listen to the
21 presentation, but since this is just preliminary draft
22 information, we won't be posting presentations and drafts
23 until the report is submitted in final form from the
24 consultants.

25 I also wanted to ask all of the folks in the audience

1 here in the room, if you haven't already, if you would please
2 make sure and make a point of signing in on the sign-in sheets
3 on the back, we'd appreciate that. And also if you're
4 interested in testifying during our public hearing a little
5 bit later today at 12:30, folks online will have an
6 opportunity to do it. You don't need to have preregistered to
7 do that, but if folks in the room are interested in doing
8 that, if you could indicate on the sign-in sheet that you
9 would like to testify later today, we'd appreciate that to
10 help us manage our time a little bit and have a sense what
11 we're doing.

12 A couple of other quick business items, too, for
13 Commission members. Those of you who are travelers should
14 have a pre-addressed, stamped envelope for your receipts, and
15 we had worked maybe six months ago or so together to create
16 the Financial Disclosure form that's required under our
17 statute now, and I had not received that back from four of
18 you. And Allen, when I did your orientation with you, I had
19 failed to go over that with you. So if you have questions, we
20 can talk about that afterwards, but for the folks who have a
21 pre-addressed, stamped envelope with that form, if you could
22 make a point of getting that back into us sometime in the next
23 week or ten days, I'd appreciate it. I have it from everybody
24 else.

25 And I think that's it, unless folks have any questions.

1 I'm not going to review the agenda for today, unless you're
2 interested in doing that right now. Heads shaking no. Does
3 anybody have any questions about our plans for the next day-
4 and-a-half before we get started? Well, why don't we go ahead
5 and turn it over to Ed and John then?

6 CHAIR HURLBURT: Yeah (affirmative). Our first session
7 will be the presentation of the draft of the third portion of
8 the report that Milliman has been putting together. With us
9 at the last meeting -- most of us in the room were here -- we
10 had a presentation of the first couple of sections, basically
11 looking at some of the what's of the costs of health care.

12 Milliman International is a highly-respected large
13 international actuarial firm, and we're the successful bidder
14 on our RFP for trying to help us understand a little more
15 about the costs of health care in Alaska.

16 The presentation today will be the third part, looking at
17 some of the aspects of the "why" stuff, of, why does our
18 health care cost what it does here in Alaska?

19 We have John Pickering and Ed Jhu will be here and will
20 be making the presentation. I think, to the extent
21 reasonable, maybe if we can have them go through the
22 presentation, then we should have ample time for discussion,
23 any questions from any of the Commission members here at the
24 table. If there is something that's just burning or is not
25 clear, I know that they would be happy to respond to that, but

1 I think, for the most part, if we can go through the
2 presentation, then we should have ample time to discuss with
3 them and among ourselves at the end. So Ed or John, whoever
4 is going first, please?

5 MR. JHU: Thanks for that introduction, and thanks to
6 everyone for having us here. I think we can probably just
7 move into the first slide, Deb, and I think Dr. Hurlburt, more
8 or less, stole my thunder on my first few slides here.

9 This is, you know, a quick slide here about Milliman. As
10 he mentioned, we are an international consulting firm, and you
11 know, a preeminent firm, particularly in health care
12 consulting, here in the U.S. So a quick slide about us, but I
13 don't think we need to go into that in too much detail, unless
14 there is anybody who is questioning our credentials here.

15 The analysis, again, was a comparison of Alaska against a
16 set of comparison states selected by the Commission as
17 Washington, Oregon, Idaho, Wyoming, and North Dakota. For
18 certain analyses, we've also included Hawaii, primarily at the
19 request of the Hospital Association. And we're practical;
20 we've also done comparisons against nationwide averages.

21 As Dr. Hurlburt mentioned, this is the third part of
22 three, in terms of the reports. The first two were presented
23 by us by phone last month and focused on the actual
24 reimbursement itself, looking at comparisons of unit cost
25 reimbursement for both physicians and facilities.

1 The third report here today is now trying to get at our -
2 - at the drivers of those cost differences, really trying to
3 understand some of the factors behind those high
4 reimbursements.

5 Just to set the stage here, our goal was to, you know,
6 identify a number of drivers, and we've tried to get a fairly
7 comprehensive report at the same time. Realistically, we went
8 into this expecting that we wouldn't be able to nail down
9 precisely, you know, all of the subcomponents that would add
10 up to the total differential in reimbursement that we've seen
11 in Alaska relative to the other states, but there are a number
12 of fairly significant factors here that, hopefully, will give
13 everyone something to think through and discuss. With that,
14 I'll turn it over to John.

15 MR. PICKERING: So Ed and I are going to switch back and
16 forth quite a bit, so we'll try to switch the mic flawlessly.

17 Let me start by introducing myself. I'm John Pickering
18 with Milliman, of course. I want to thank the Commission for
19 having us here to address you folks. We appreciate the
20 opportunity.

21 The slide that's up right now is the road map that we're
22 going to follow today, and you'll see this slide a few times
23 throughout the presentation as we walk down the various paths,
24 but to give you an idea of the route we'll take, we're going
25 to start with commercial premiums in Alaska relative to other

1 states. And from an actuarial perspective, we often think of
2 the premium as split between the utilization component and the
3 cost per service. So how efficiently are services delivered?
4 That's the utilization component. What do you pay per unit of
5 service delivered? Obviously, the cost per unit component.

6 So within each of those two big drivers of total health
7 care costs, we'll drill down and try to assess, you know,
8 whether those are drivers of the overall high level of costs
9 in Alaska. I won't go through all the various subcomponents,
10 but just try to keep this dynamic in the back of your minds,
11 utilization and unit cost, as we go through the presentation.

12 MR. JHU: So moving on to the next slide then, the first
13 focus of our analysis on the actual commercial premiums
14 themselves. This is really an all-encompassing start to
15 looking at health care is looking at the costs of the premiums
16 themselves, and we've chosen two separate analyses that we'll
17 look through here, one of which is using data from a Milliman
18 survey and the other one of which is from the AHRQ's Medical
19 Expenditure Panel Survey (MEPS).

20 So first, a couple details about the Milliman survey.
21 It's performed almost annually, sent to a number of HMOs,
22 PPOs, insurers. We get a fairly good response rate, and the
23 idea of the survey is that companies are sent, and the survey
24 itself is sent, to the insurers. They're asked to respond
25 based on what their premium would be for a very specific plan

1 design and for a specific contract type. As a result, it gets
2 to something that's normalized to take into account
3 differences in population mix and differences and other
4 factors across areas or across insurers and really gets down
5 to, you know, for a very equivalent health care plan design,
6 what would you be charging as far as a premium.

7 Unfortunately, since it is a survey, like any survey
8 information, we don't necessarily have complete information
9 across the country, and as noted at the bottom of this slide,
10 we didn't have sufficient information in either North Dakota
11 or Wyoming in order to add them to the survey, but we do still
12 have a number of the comparison states.

13 And the slide here shows the results. Hopefully, it's
14 visible to those in the back of the room. If not, I'll go
15 over this in rough detail, but essentially, the critical point
16 here is that the average health care premium -- commercial
17 health care premium in Alaska is looking at approximately 130%
18 or so of the comparison states. Where, in this case, the
19 comparison states are being restricted to Idaho, Washington,
20 and Oregon.

21 And towards the bottom of this slide, it does indicate
22 also that the comparison states, themselves, are slightly
23 higher than the overall nationwide average also, though by a
24 relatively small amount.

25 I mentioned the second study that we looked at was an

1 external study produced by AHRQ and it's their Medical
2 Expenditure Panel Survey. It's a survey that's performed, you
3 know, to determine costs, and this survey, unlike the Milliman
4 survey, is done from the ground up, so to speak, as far as
5 working with individuals and families and getting responses on
6 that basis. But we see largely similar results from this
7 survey that, once again, Alaska is coming through at 126% of
8 the average of the comparison states. In this case, we do
9 also have Idaho -- or have North Dakota and Wyoming in the
10 comparison states. Though, based on the averages, they didn't
11 move things terribly much as far as having them in there. And
12 once again, we see the comparison states somewhat inline with
13 the nationwide average, though, in this case, slightly lower
14 as opposed to slightly higher.

15 So overall as far as conclusions on the premiums -- and I
16 don't think this will surprise too many people here in the
17 Commission or in the room -- we did find that commercial
18 premiums in Alaska are approximately 25% to 30% higher than
19 the comparison states, and really, the main focus of our
20 analysis then was the parts after this, trying to really
21 identify what some of the drivers are behind that high cost.

22 MR. PICKERING: So starting to try to explain that
23 approximately 30% differential in premium, we'll first go down
24 the utilization branch of the tree. And actually, Deb, if you
25 could go two slides forward? One more. I'll talk through it

1 while we have the chart up there, so folks can review the
2 chart rather than the words.

3 This is a study done by the Medical Payment Advisory
4 Commission (MedPAC). And what they did was, nationwide, they
5 stripped out unit cost payment differences for Medicare
6 beneficiaries and evaluated just resource use, and it was done
7 on an age/sex adjusted basis and a health risk adjusted basis.
8 So they have a health risk score for every beneficiary and
9 normalized the results for that health risk, such that I think
10 it's a well-done and rigorous study isolating utilization use
11 and not payment-per-service.

12 And what this shows is Alaska is very efficient from a
13 utilization standpoint relative to the rest of the country.
14 As you can see, the highlighted 87%, meaning Alaska, on
15 average, used 87% of the resources to treat a Medicare
16 beneficiary relative to what the nationwide average was. That
17 ranked Alaska as the third lowest resource use state, so quite
18 impressive.

19 Now when you do compare Alaska to the comparison states
20 in our study, it ranks at 100% of that average, but that's
21 because those comparison states are also among the most
22 efficient states in the country. So you can see Hawaii,
23 MedPAC ranked it as the most efficient from a utilization
24 standpoint at 76% of the national average, and you can see the
25 other states. But I think the takeaway is, you know, from

1 this pretty comprehensive study, Alaska looks like -- the
2 utilization is efficient and is not a drive of that 30%
3 premium differential.

4 And Deb, I'm going to ask you to go one more. I'll talk
5 through it while the charts are on the screen.

6 So this next slide are results from the Milliman Health
7 Cost Guidelines. Every year, as a company, we put our Health
8 Cost Guidelines and we license them to -- mainly to health
9 plans around the country to help the health plans price health
10 insurance, and one component of that is looking at the health
11 care utilization by area.

12 So what we've done in this slide is to present, for the
13 comparison states and for Alaska, what our Health Cost
14 Guidelines, the Milliman Health Cost Guidelines project for
15 utilization, and unlike the MedPAC study where they rolled all
16 of utilization on a consistent basis into one number,
17 essentially counting up the relative value units, we don't
18 have that in our guidelines.

19 So what we've presented here is a glimpse at four key
20 health care service categories. So we show in-patient bed
21 days per thousand in the first two columns and then ER visits,
22 office visits, and prescription drugs, scripts.

23 And I think the first thing I'd like to draw your
24 attention to is looking at the Alaska average relative to the
25 nationwide average, and let's start with inpatient bed days.

1 So you can see on the chart there, we project inpatient
2 bed days in Alaska to be 283. What that means is that, for a
3 thousand people -- and this is a commercial population, you
4 know, under age 65 -- we would estimate approximately 283
5 inpatient bed days for every thousand people per year. You
6 can see that's right inline with the national average, which
7 is also at 283.

8 Scanning across the other categories, ER visits, Alaska
9 at 221 relative to the national average of 178. So Alaska
10 looks a little high there. Office visits, Alaska is right
11 inline at 2,800 compared to the national average, and Alaska
12 is low on prescription drug scripts relative to the nationwide
13 average. So maybe not as rosy a picture as MedPAC painted,
14 but you know, still, essentially, inline with the nationwide
15 average.

16 When we do switch the focus to looking at the comparison
17 states, Alaska performs a little bit worse, and again, I think
18 this is because the comparison states are some of the most
19 efficient in the country. You can see -- and actually, the
20 second column under each service category shows the ratio to
21 the comparison states. So Alaska's bed days are 121% higher -
22 - or excuse me, 21% higher than the comparison state average.
23 ER visits are 15% higher. Office visits are approximately
24 inline at 3% higher, as are prescription drugs at 1% lower.

25 I think there is one really interesting dynamic to pull

1 out of this slide though and that's when we split Alaska
2 between the MSA areas -- MSA is a Metropolitan Statistical
3 Area. So these are the more urban areas of the state, and
4 it's Anchorage, Fairbanks, and MatSu. Throughout this
5 presentation, that's our MSA area versus the non-MSA area.
6 It's always that same breakout.

7 What we see here in Anchorage, Fairbanks, MatSu, in that
8 MSA areas, inpatient days are a lot lower than the statewide
9 average. So 193 bed days per thousand here in the urban
10 areas, or you know, 18% lower than the comparison state
11 average. The other service categories, ER, office visits, and
12 prescription drugs, don't show nearly as much differential,
13 but the inpatient days appear to be, you know, a lot lower in
14 these urban areas as opposed to the rural areas. Go ahead,
15 Deb.

16 This next slide are values from the Dartmouth Atlas that
17 look at surgical replacements per thousand, Medicare enrollees
18 per year. I'm not sure there are any great takeaways from
19 this slide, but we had this as a data point, so we wanted to
20 include it. What this does show, I think, is that, you know,
21 if you compare the top line, which is Anchorage, first to the
22 nationwide average, which is the bottom line, you know, the
23 hip replacements per thousand are a little bit less than the
24 nationwide average, but certainly not out of line, high or
25 low. The knee and shoulder are a little bit higher in

1 Anchorage than the nationwide average, but not really out of
2 line high or low. So you can see the comparisons to various
3 areas in the comparison states, but I think the takeaway from
4 this slide is showing that there are no real outliers on, at
5 least, these three procedures in Alaska. And one more.

6 MR. JHU: So next moving in, we had wanted to take a
7 slightly further, a deeper look into things. John had
8 mentioned the relative utilization of inpatient days in Alaska
9 versus the comparison states, and ultimately from an actuarial
10 standpoint, we tend to focus predominantly on days of stay as
11 opposed to admission because, ultimately, it does reflect a
12 greater degree of the severity of admissions, and ultimately,
13 the costs incurred are largely incurred on a per-day basis as
14 opposed to an admit, that there is certainly a much higher
15 cost associated with a ten-day stay than a two-day stay.

16 But at the same time, looking at the days does beg the
17 question of whether the higher -- or you know, the differences
18 that we see in terms of the relative utilization of hospital
19 days are driven by differences in admissions or differences in
20 the average length of stay. And so we had done a separate
21 analysis to look at the relative length of stay in Alaska
22 versus the comparison states.

23 In order to normalize for admission rates and the
24 severity of admissions, what we had done, essentially, is
25 looked at an average length of stay nationwide by DRG, so

1 diagnosis-related group that really group up inpatient stays
2 into fairly similar categories, and then produced a benchmark
3 based on the mix of DRGs within each state as to what the
4 nationwide average length of stay would have been for that
5 particular mix of cases and then compared that to the actual
6 average length of stay within each state. And what you can
7 see here in this study is that Alaska does have a higher
8 average length of stay than the comparison states, 113%, and
9 in fact, is, once again, similar to the nationwide average,
10 which was 112% of the comparison states.

11 One point to note here though is that the differential
12 that John had shown in the previous slide for the -- you know,
13 between the urban areas, Anchorage, Fairbanks, MatSu, versus
14 the non-MSA areas isn't shown here. Our theory behind that is
15 there is a slight difference in terms of the methodologies
16 involved, that the previous slide showing the Milliman
17 utilization benchmarks are intended largely for pricing, and
18 as a result, the benchmarks, themselves, are developed based
19 on the location of the member as opposed to the location of
20 the facility.

21 For this study here, we had focused on the location of
22 the facility, itself, since we were looking at the admissions
23 that were occurring at each facility. Potentially one of the
24 things occurring is that you're getting a number of people
25 from some of the outlying areas who, perhaps due to some of

1 the more severe conditions, are coming into the urban areas in
2 order to get their treatment, and both the -- as much as we've
3 accounted for the relative severity or tried to through DRGs,
4 it's possible that some of the additional severity that might
5 not be captured through the DRGs is coming through in higher
6 lengths of stay and also just the practical elements of
7 discharge for somebody who has, presumably, been traveling a
8 long way in order to get to their facility means that you may
9 or may not end up with higher average lengths of stay. So as
10 a result, if we were to look at the Anchorage, Fairbanks,
11 MatSu average length of stay for just the patients who were
12 local, I would hazard a guess that we would see somewhat lower
13 lengths of stay, a little more inline with the previous slide,
14 and that the number here is being somewhat elevated because of
15 the rural enrollees who are being shipped in to those urban
16 hospitals. Next slide, please.

17 So just a quick conclusion as far as the utilization
18 elements and end of things. Again what we found is that
19 Alaska is, more or less, inline with the comparison states,
20 and as a whole again, the comparison states are some of the
21 best in the nation as far as utilization efficiency. And so
22 as a result, we don't think this is a major contributor or
23 factor towards the higher premiums either.

24 And so as John had mentioned earlier, ultimately, the
25 premiums come from either utilization or unit costs and so we

1 had done some analysis into the relative unit costs and some
2 of the drivers behind the higher unit costs that we see in
3 Alaska.

4 As we started with, we had indicated that this is
5 actually the third of three reports. We're not going to spend
6 too much time on the previous two reports, but the next couple
7 slides have a quick summary. And Deb, if you want to move
8 over to the next one?

9 We had done two previous analyses, one focusing on unit
10 cost reimbursement for physicians and one on facilities. Both
11 had arrived at, you know, somewhat similar results, and once
12 again, not unexpected that unit costs per service in Alaska
13 are higher than the comparison state averages. And these
14 analyses both had normalized the relative utilization to
15 reflect or to offset any differences that may be occurring in
16 terms of the severity of services between Alaska and the
17 comparison states, and as a result, what we're seeing here is
18 really our best estimate of the equivalent cost -- the cost in
19 Alaska relative to the comparison states for an equivalent
20 service.

21 And just to highlight some of these numbers here, what we
22 see are the commercial allowed charges in Alaska are 167% of
23 the average in the comparison states and that, in general, the
24 comparison states, while there is some fluctuation, tend to be
25 in a fairly narrow bend, considering how far out Alaska is

1 relatively. We also see that, across other payer categories,
2 Alaska is fairly consistently higher. And Deb, if you want to
3 slide to the next slide?

4 On the hospital side, we saw similar results where we see
5 that reimbursement in Alaska is, give or take, approximately
6 140% of the comparison states, and this slide here is focused
7 on commercial reimbursement, but in our initial report, we did
8 also do some similar analyses on Medicare reimbursement for
9 facilities.

10 So having gotten to this point, really what we're trying
11 to focus on next is why, looking at a number of possible
12 factors that would explain the higher reimbursement that we're
13 seeing in Alaska relative to the comparison states.

14 MR. PICKERING: I'll interject just real quickly here.
15 As we go through the rest of this slide or the rest of the
16 presentation, I think there are two important numbers from
17 those last two slides to keep in mind and that's the 167%
18 relative unit cost for physician commercial and then 137% on
19 hospital. So those are the two numbers we're really going to
20 try to drill into now and understand what are the drivers of
21 those higher unit cost ratios.

22 MR. JHU: As we go through these, I think we'll probably
23 repeat those numbers a few times because, as John said, it is
24 important to, you know, see that. Certainly in other areas,
25 we are seeing fairly consistently Alaska coming in with

1 numbers that imply higher costs in other areas. At the same
2 time, depending on the situation, we're not necessarily always
3 seeing costs or seeing relativities in Alaska that do get as
4 high as the overall unit cost reimbursement relativities that
5 we've seen.

6 So one of the first pieces we focused on was for hospital
7 costs themselves. By costs here, just to make everyone -- get
8 everyone on the same page, we're referring to the actual costs
9 incurred by the facilities themselves, so the true cost of
10 operations for the hospital, the theory here being,
11 presumably, that, ultimately, a hospital's reimbursement can
12 be broken down into two pieces. Like any business, there is
13 what it costs them to actually provide those services and then
14 there is their margin, which is the differential between what
15 they're actually paid and what it's going to cost at the end
16 of the day.

17 So we had focused first on those two pieces. I'll go
18 over the cost portion and then pass it to John for the margin
19 piece.

20 To get at the costs, we had focused on data from
21 Medicare. We had used all hospitals, but excluding the
22 federal and tribal hospitals. So essentially, your "normal"
23 facilities, as it were, that would typically be seen in most
24 of the comparison states. We had used data from Medicare.
25 For the inpatient services, we had used the MedPAR data set,

1 which has quite a level of detail. And then for outpatient
2 services, we had focused on the Outpatient Prospective Payment
3 System and also the Medicare 5% Sample for facilities that
4 aren't paid under OPPTS.

5 So the tool, itself, that we used to ultimately evaluate
6 the hospital costs was RBRVS for Hospitals. For those who
7 were in attendance at our initial presentation, we had focused
8 on -- we had used the same methodology to develop our analysis
9 of Relative Commercial Reimbursement and Relative Medicare
10 Allowed Reimbursement. So the tool, itself, is similar.

11 Just as a quick reminder, essentially what we do is we
12 take all of the workload in the various data files that we're
13 looking at. The RBRVS tool assigns Relative Value Units to
14 each procedure. So on the inpatient side, it's based on each
15 day of stay and the specific DRG. And on the outpatient side,
16 it's based on CPT and HCPCS codes. And as a result, we're
17 able to normalize for the relative severity of the workload
18 and the patients, and ultimately, we can take the total
19 allowed dollars divided by the total RVUs to get a conversion
20 factor, or in this case, we can do something equivalent where
21 we can take the total costs reported on each claim divided by
22 the Relative Value Units in order to arrive at a cost per
23 unit. And I think, Deb, you can slide by the next slide here.

24 This is just a quick example. And here, we see the
25 results of our cost analysis, and what we found is that the

1 Anchorage and Fairbanks areas are higher than the comparison
2 states as is the overall Alaska total by about 140%, 146 in
3 Anchorage, 157 statewide. That 157 is elevated significantly
4 by significantly higher costs in some of the outlying here,
5 the non-MSA areas, which are almost double the cost of the
6 comparison states.

7 The next slide tries to normalize for anticipated
8 differences. We've applied a geographic adjustment. This is
9 similar, again, to the approach that we had used when we
10 looked at the Medicare allowed charges themselves, where we
11 had used Medicare unit cost differentials and Medicare
12 reimbursement in order to estimate what we would anticipate
13 the relative cost differences to be and backed those out of
14 total cost differences. And what we see is this does bring
15 Alaska closer in line to the comparison states, but still, we
16 see a differential of 40% in aggregate, higher reimbursement
17 in Alaska, and again, slightly lower than that in the urban
18 areas and fairly significantly higher in the non-MSA areas.
19 On to the next slide.

20 And this just summarizes those statements that I had made
21 earlier that what we're seeing is that, you know, the cost per
22 unit of care in Alaska is, not surprisingly, higher than what
23 we've seen in the comparison states, and I think that's the
24 conclusion that we had anticipated heading into this analysis
25 and the data supported our expected results.

1 MR. PICKERING: So the big picture, hospital operating
2 costs are higher than the comparison states by quite a fair
3 margin. Let's turn our attention to the hospital margins or
4 how much the hospitals make in Alaska relative to the
5 comparison states.

6 What we summarized coming up here is data from the
7 Medicare cost reports, and we used the three most recent years
8 available, 2008 through '10, and these are all based on each
9 hospital's own reporting of its cost report, which is on a
10 hospital fiscal year basis. So the years aren't quite
11 calendar year bases, but good indicators nonetheless. And
12 Deb, go ahead and flip the slide.

13 MR. PICKERING: We show three types of margins here. So
14 the first three columns on the left focus on the All Payer
15 total margin. Now this is a total margin, and it includes
16 non-operating performance. So it includes things like
17 investment income, contributions. So more than just, you
18 know, patient operating results.

19 The middle three columns try to strip out some of the
20 main, non-operating components from the total margin. So we
21 call it the approximate operating margin. From the cost
22 reports, we can't get to a pure operating margin, but we can
23 get fairly close. So what we've done is to remove investment
24 results and contributions from the total margin to get to the
25 approximate operating margin.

1 And then the last three columns present the Medicare
2 operating margin or the margin that the hospitals are making
3 on Medicare business.

4 In terms of what this data tells us, I think the All
5 Payer total margins and the All Payer operating margins really
6 tell the same story. So I'd like you to focus on the All
7 Payer operating margins to start with, and if we just look at
8 the Alaska total, in 2008, a 9.8% margin, in 2009, an 11.2%
9 margin, in 2010, a 13.4% margin. In looking through some of
10 the underlying details, it looks like 2010 might be a little
11 bit of a high outlier. So the column I recommend focusing on
12 is 2009, an 11.2% margin. If we compare that 11.2 to what we
13 see in the comparison states and nationwide down at the bottom
14 of the slide, the average hospital margin for the comparison
15 states is 3.9% and a nationwide average of 3.8%. So the
16 difference between the 11.2 that we see in Alaska and the 3.9
17 in the comparison states represents 7.3 extra points of
18 margin.

19 Now focusing on that 2009 column still and looking at how
20 that 11.2 is built up, on the top line, we, again, show the
21 MSA area, so the Fairbanks, MatSu, and Anchorage areas, and we
22 see a 13.4% margin in those areas combined with a 5.2% margin
23 in the more rural areas to get to that 11.2. And as you scan
24 across years, you can see that it bounces around a little bit,
25 but the differential appears to be pretty robust. It seems to

1 occur each year, at least these three years that we've looked
2 at. And you know, focusing then a little bit more on that top
3 line, the 13.4% margin of the hospitals in Anchorage,
4 Fairbanks, and MatSu, you know, that's not saying every
5 hospital has a 13.4% margin. That's not the way that that
6 margin gets developed. Looking at the detail, it's really a
7 couple of the hospitals that have 20%-plus margins rolled
8 together with a couple hospitals that have margins that are
9 more typical in line with the rural areas in some of the
10 comparison states.

11 The right-most columns, the Medicare operating margins,
12 tell kind of an interesting story as well. Notice that
13 Alaska, in total -- again, let's focus on 2009-2010. Again,
14 it appears to be kind of an outlier, but 2009, a negative 18%,
15 so losing 18% on Medicare business. That compares to a
16 nationwide average of hospitals losing 3.3% on Medicare
17 business, and in the comparison states, losing 9.6% on
18 Medicare business. So you know, what we would infer from this
19 is that the -- while Medicare does pay hospitals more on a per
20 unit basis here in Alaska than the comparison states, it's not
21 enough to offset the hospitals' extra costs here in Alaska so
22 that the negative margin on Medicare business is more negative
23 here.

24 There is one interesting thing to point out on this
25 slide. If you focus on the non-MSA areas, the Medicare

1 operating margins, you'll see those are quite negative, -20%,
2 -18% approximately, -17%. A lot of these are critical access
3 hospitals where inpatient and outpatient services are paid on
4 a cost basis. So when you drill down on the details of this
5 Medicare margin, the inpatient and outpatient services at
6 these hospitals are making at 1% margin because that's,
7 essentially, how they are paid by CMS, costs plus 1%. What's
8 driving these large negatives are swing bed skilled nursing
9 facility numbers. So interesting to -- I was surprised that
10 the swing bed SNF could shift the overall margin by that
11 magnitude, but I guess it hammers home the importance of those
12 services in the rural areas. Go ahead, Deb.

13 The next thing we'll look at -- we're going to kind of
14 shift the focus back to drilling into the hospital operating
15 costs that Ed showed at the high level and see if we can
16 identify some of the drivers behind those operating costs,
17 which are higher than the comparison states.

18 So one element that we looked at was hospital occupancy
19 rates, and we define the occupancy rate as occupied bed days
20 divided by available bed days. Pretty straightforward. These
21 come from the cost reports as well, so self-reported by the
22 hospitals. And why do we look at this? Well, unoccupied
23 beds, of course, are idle resources. The higher the occupancy
24 rates are the more patients, the more revenues being generated
25 to help cover those fixed costs that aren't going away whether

1 there are patients in them or not. So all else equal, you
2 know, higher occupancy rates are associated with lower per
3 unit patient operating costs and lower occupancy rates are
4 higher as you have the idle resources.

5 So the next slide shows the results, and I think these
6 results are interesting, but not surprising. What it shows --
7 and here, I'd focus on the 2010 column. If we start by
8 looking at Alaska in total, we show a 49.9% occupancy rate, so
9 approximately 50%, which is a little bit lower or quite a bit
10 lower than the comparison state average at 58% and also lower
11 than the nationwide average at 60%. However when you look at
12 the more rural states in the comparison states of Idaho, which
13 is at 45.9%, North Dakota at 49.5%, and Wyoming at 39.1%, you
14 see those numbers are more in line with what we're seeing for
15 the Alaska total, and I think the Alaska split between the
16 urban MSA areas and the non-urban areas bear out this point as
17 well, where you see the approximately 39% occupancy rate in
18 the rural areas and 53 in the MSA areas. You know, in the
19 rural areas, you see a lot of variance in census counts at
20 hospitals, and it's quite common to have lower occupancy rates
21 than in more urban areas. Next slide. And one more. I
22 talked through those bullets already.

23 The next element we looked at to try to understand the
24 operating costs at hospitals was staffing ratios, and
25 industry-wide, there are a few different definitions of

1 staffing ratios. So we want to be real clear how we're
2 calculating these numbers and that's full time equivalent
3 (FTE) nursing staff per occupied hospital bed, and these come
4 from the Medicare Provider of Services file. It's a file that
5 Medicare puts out quarterly. It has a lot of provider
6 information. Next slide, Deb.

7 So what we see here -- let's focus on the Alaska total
8 first. We see an FTE -- a full time equivalent registered
9 nurses per occupied bed of 2.58, so almost 2.6, relative to
10 the comparison state average of 2.0, so you know, 0.6 more of
11 an FTE per occupied bed day. The split here between Anchorage
12 and the rural areas -- you know, Anchorage is higher, 2.7
13 FTEs, in the rural areas, a little bit lower, 2.35. And you
14 can see, looking at the comparison states, the ratios really
15 bounce around quite a bit. Hawaii, 2.47. It's kind of
16 interesting. Overall utilization, Hawaii is very utilization
17 efficient, which the staffing ratio really doesn't talk about
18 utilization efficiency, but you know, Hawaii has been able to
19 couple utilization efficiency with a little bit higher
20 staffing ratios. Idaho's staffing ratio is quite high, of
21 course, a more rural area. Whereas some of your other or one
22 of your other rural areas of North Dakota at 1.7, quite a bit
23 lower. So you know, I honestly don't know if this is really
24 practice patterns from area-to-area or what drives these
25 differences, but on a net basis relative to the comparison

1 states in total, you do see Alaska about 25%-30% higher on the
2 staffing ratio.

3 MR. JHU: So moving next into a couple of areas, looking
4 at the compensation and the actual salaries paid to medical
5 professionals, obviously, this being a fairly significant
6 component of the overall costs are incurred. Once again on
7 the compensation piece, we've used a couple different
8 methodologies just to gather somewhat a consensus of sources,
9 one of which is from internal Milliman information where we
10 have annual salary surveys that are conducted across a number
11 of industries and a number of states. We've chosen two, one
12 of which is a cross-industry survey that we perform in Alaska,
13 and the second of which is a health care-specific industry
14 survey done in the Pacific Northwest, so focusing on
15 Washington, Oregon, and Idaho. And Deb, if you move onto the
16 next slide?

17 There are a lot of numbers here, but we can just focus on
18 some of the key results. What we had from this survey was
19 only non-physician results. So primarily, the largest
20 position in terms of volume of employees, by far, was the
21 registered nurse group, and what we see here is that
22 registered nurses in Alaska are paid approximately at the same
23 rate as they are in those comparison states, Washington,
24 Oregon, and Idaho.

25 And looking through the other numbers here and for the

1 other positions on the survey, as well as the overall average,
2 which is at the bottom of the screen and may not be visible to
3 those of you in the back of the room, but what we see here is
4 that salaries, although slightly higher in Alaska for medical
5 professionals, are not significantly higher than -- sorry.

6 COMMISSIONER LAUFER: I'll just tell you, for a locum
7 ultrasonographer, it's about \$160 to \$180 an hour here, which
8 is about twice what a pediatrician or a primary doc is paid.
9 I can tell you that because we've been looking for years.

10 MR. JHU: Okay. And ultimately, this is the information
11 from the survey, but certainly, as with any survey, there is
12 margin for error.

13 COMMISSIONER LAUFER: (Indiscernible - away from mic)
14 \$10,000 finding fee.

15 MR. JHU: And so what we show is a number of different
16 ratios here as far as the salaries in Alaska relative to the
17 comparison states.

18 Moving to the next slide, we did have a second source,
19 which is data from BLS, and again, we've got a fair number of
20 positions here. Of note, we also did get physician and
21 surgeon salaries in this information from BLS. And once
22 again, there are a lot of numbers, but probably, I'd encourage
23 everyone to focus on the far right, which shows the ratio of
24 the salaries in Alaska compared to the comparison states.

25 Here, it shows slightly higher salaries in Alaska

1 compared to what we had seen on the previous slide, physicians
2 and surgeons at about 110%, moving in -- you know, getting
3 slightly higher with therapists, where we're getting up to
4 25%, but in general, these numbers are still coming in below
5 what we had seen in some of those initial slides as far as the
6 relative unit costs, which we're showing commercial
7 reimbursement for physicians at about 50% or 60% higher than
8 the comparison states, and overall, reimbursement for
9 physicians at -- or professional services rather at
10 approximately 40% to 50% higher than the comparison states.

11 A few other metrics that we thought would be interesting
12 as far as putting the relative health care reimbursement in
13 perspective, we had looked at the relative cost of living
14 based on the ACCRA Cost of Living Index. And Deb, if you'd
15 just flip over to the next slide?

16 Once again, a lot of numbers, but we see a somewhat
17 similar conclusion here that the nationwide average cost of
18 living is a 1.0 by definition here on this index. What we see
19 is, if you look at the comparison states, the numbers that are
20 not in bold, the numbers, in general, float somewhere in and
21 around 100%, the exception being Honolulu, but certainly for
22 the comparison states in the Lower 48, we see numbers that are
23 roughly around 100%. By comparison looking at the numbers in
24 Alaska, the composite index, which measures the total across
25 all of the various elements that are listed to the right, we

1 see that Anchorage is running around 130% or so of the cost
2 elsewhere, and we see somewhat similar results in the 130% to
3 140% range for the various other areas listed on the survey.
4 Go ahead.

5 COMMISSIONER HIPPLER: Do you have later, a breakdown of
6 the cost of living just in those states that we're comparing
7 ourselves to as comparison?

8 MR. JHU: Well, this is just a list of comparison states
9 or were you looking for an overall average across these
10 states?

11 COMMISSIONER HIPPLER: Yes.

12 MR. JHU: We don't have anything offhand; no. So at
13 least by observation, you know, looking at the composite
14 index, there are certainly some areas that run over 100%,
15 particularly in some of the urban areas, as you'd expect,
16 Seattle and Portland. By comparison, you're getting below
17 100% in, you know, most of the other areas in Idaho, Wyoming,
18 North Dakota, some of the more rural areas, but I think that
19 was consistent with what we would have expected.

20 MR. PICKERING: I would suggest just eyeballing it,
21 looking at the larger urban centers where you have more
22 population. As Ed was saying, Seattle shows a 121, Portland a
23 111, you know, offsetting some of the lower, the 90s. I would
24 guess, you know, you're probably around a 105 to 110 average,
25 somewhere in there.

1 MR. JHU: Which means, roughly speaking, that, with the
2 130 or so in the Alaska areas, you're looking at about a 20%-
3 25% increase in cost of living over and above what's being
4 seen in the comparison states as a rough number.

5 COMMISSIONER DAVIDSON: (Indiscernible - away from mic)

6 MR. JHU: Anchorage; yes, the Alaska areas that are
7 listed here.

8 COMMISSIONER LAUFER: (Indiscernible - away from mic)

9 MR. JHU: Yeah (affirmative), and unfortunately, we don't
10 have any numbers for rural Alaska here, but certainly, given
11 some of the numbers we've seen elsewhere as far as the
12 relative costs in rural Alaska, I would guess that the rural
13 Alaska numbers would be higher than what we're seeing here.
14 Deb, moving on to the next slide then.

15 One thing that we looked at, and this is somewhat moving
16 away from a pure analysis of the cost in numbers and trying to
17 get into why the costs -- or where they are, we had looked at
18 primary care physician shortages, and what these are, these
19 are metrics developed by the Health Resources and Services
20 Administration Shortage Designation Branch. Essentially, they
21 develop a set of criteria, and based on that, label areas as
22 being medically underserved or having shortages in either
23 primary care, dental, or mental health. For this purpose, we
24 had focused on the primary care shortages.

25 Just to give some broad perspective, there is a quote at

1 the bottom here from their website that, as of September 21st
2 of this year, there were 6,433 primary care health care
3 shortage areas, which, combined, accounted for 67 million
4 people. So for the broad -- and moving into the next slide;
5 yes. Thank you.

6 What this slide here shows -- and this is data from 2008
7 -- is the percentage of the population that's underserved, and
8 you can see here we have the nationwide average at 11.8%, and
9 interestingly, of the comparison states, Alaska is the one
10 that's closest to the nationwide average at 12.1%, where there
11 are some states -- three of the comparison states, in fact --
12 below Alaska and three above with Alaska, again, falling
13 somewhere right in the middle. So as far as this, it sort of,
14 I think, gives some indication of having discussed the
15 relative reimbursement for physicians. What we find is that,
16 at least at this point relative to the nationwide average,
17 Alaska, in terms of the availability of primary care
18 physicians, is somewhat inline with the nationwide average
19 that you're neither significantly above, which might suggest
20 some over-reimbursement, or significantly below, which might
21 suggest the need to be increasing reimbursement. At the same
22 time, this is a single metric as far as the availability of
23 physicians, and certainly, I think there are a lot of other
24 factors that need to be considered overall in terms of getting
25 down to the decision of where physician reimbursement and

1 professional reimbursement is in Alaska and whether or not
2 that's at the level that you, as a state and you as a
3 Commission, are comfortable with as far as overall payment.

4 And Deb, if you move on, one additional analysis, as we
5 were focusing through, we also looked provided discounts. As
6 most of you are aware, the majority of the time -- provider
7 discounts, in this case, being what providers are actually
8 reimbursed relative to their billed charges. In the majority
9 of health care settings at this point, billed charges are not
10 a metric that's actually being enforced, that, typically, most
11 providers aren't able to recoup their billed charges, and I
12 would hazard that many are not expecting, at this point, to
13 recoup their billed charges in the majority of situations. At
14 the same time, being able to look at the discounts provides a
15 bit of a perspective on where the relative market forces are
16 in each of the states that we're looking at.

17 In general, what we would expect to see are areas that
18 might have more -- where more of the power, so to speak, is
19 with the providers, there would be relatively lower discounts,
20 and in fact, the insurers and the payers would generally be
21 paying closer to what the providers are requesting through
22 their billed charges. By comparison, in areas potentially
23 where more of the sway is held by the payers themselves, we
24 would expect to see higher discounts.

25 And moving on to that next slide then, we can see the

1 results here, and this is from Milliman data for non-Blues
2 plans, and what we see is that the discounts in Alaska for
3 hospital services are comparable to the comparison states.
4 Alaska is fairly close to Oregon, lower than Washington, and
5 you know, higher than Idaho or Wyoming. At the same time,
6 what we see is that, on the professional side, the discounts
7 in Alaska are lower than what we're seeing in all of the
8 comparison states. Yes?

9 COMMISSIONER LAUFER: You said this is for non-Blues
10 plans?

11 MR. JHU: This is non-Blues plans; yes.

12 COMMISSIONER LAUFER: The Blues are a big chunk of.....

13 MR. JHU: Yes. So.....

14 COMMISSIONER LAUFER: Yeah (affirmative), 62%, something
15 like that.

16 MR. JHU: Unfortunately, that's just the data source
17 that's available to us. It wasn't a deliberate attempt on our
18 part to remove the Blues plans to adjust the results. But
19 overall, what we see is that, again, the discounts are
20 comparable to the comparison states on the facility side, but
21 lower on the professional side. Deb, if you move onto the
22 next slide? Thank you.

23 And so overall again, our conclusions as far as unit
24 costs, on the hospital side, we do have high commercial
25 payments, and what we've seen is that the operating costs are

1 high and consistent with our expectations, somewhat reflecting
2 Alaska's position as far as the relative mix of providers and
3 some of the geographic difficulties that the state faces. At
4 the same time, especially in the urban areas, what we see is
5 that the hospital margins are significantly higher than the
6 comparison states or what we typically see nationwide.

7 On the professional side, we've also seen that the unit
8 costs are high. We can't -- there is no equivalent to some of
9 the reporting that we see on the hospital side. As a result,
10 we can't explicitly isolate the margins the same way we can on
11 the hospital side. At the same time, you know, what we see is
12 that there are some high operating costs associated with the
13 costs of living and also associated with higher relative
14 salaries for medical professionals. At the same time,
15 typically, those are coming in below what we're seeing as far
16 as the differential in unit cost reimbursement.

17 MR. PICKERING: So next, we'll look at the insurance
18 distribution among payers, and this doesn't neatly fit under,
19 you know, any one piece of our tree here, but it's an
20 important consideration as -- you know, thinking of providers'
21 total incomes. In our first couple studies, we had charts
22 that showed Medicare payment relative to commercial, relative
23 to Medicaid, relative to some other sources, and what you see
24 in Alaska, as well as almost every other state, is commercial
25 insurance payment is higher, followed by -- I think, in

1 Alaska, it was Medicaid and then Medicare. Often, that's
2 switched in other states where Medicare pays better than
3 Medicaid. But from a provider's perspective, if you have more
4 of these lower paying payers, there may be a need to have
5 higher prices on your commercial business to offset some of
6 those lower payments from public providers, and there is a lot
7 of academic discussion of cost-shifting and whether it really
8 exists. From a practical perspective of working with health
9 plans, I think you do see it. So Deb, if you could go to the
10 next slide, we'll look at the distribution here.

11 This comes from Kaiser StateHealthFacts website, a
12 commonly used website with health care information. A few
13 things I want to draw your attention to on this slide. First
14 of all, if we look at Alaska, the first thing that jumps out,
15 to me, is the low Medicare percentage. So this is saying
16 that, in Alaska, only 8% of the population is covered by
17 Medicare. That's a lot lower than the U.S. average at 12%, or
18 really, any of the comparison states.

19 The second thing that jumps to out, to me, is looking at
20 that other public column where Alaska is a lot higher than
21 either the U.S. as a total or the comparison states. So a lot
22 of that is military personnel.

23 And number three, look at that uninsured number at 19%,
24 and I guess we don't have it noted here. I'm not entirely
25 sure when -- what the time period is of this, but it would

1 have been the most recent time period that was available on
2 the website. So 19% in Alaska, higher than the nationwide
3 average at 17% and even more higher -- that might not be the
4 right wording, but than the comparison states shown here.

5 Now one thing I like to focus on, if you add together in
6 your mind -- we don't have it on this slide, but the employer
7 number and the individual number, those two, together, are the
8 commercial payers, or you know, commercial payers would have
9 both employer group coverage and individual coverage. So from
10 a provider payment level, I often think of those as combined.

11 So here, we see Alaska adding the 51% and the 4% at a
12 total of 55%, which is the lowest of any of the comparison
13 states, although it is a tic higher than the U.S. average. So
14 given that the commercial payment as a percent of total
15 payment is less in Alaska, you might expect a little bit more
16 cost-sharing pressure. I think some of that gets offset by
17 the relatively high Medicaid payment levels in Alaska. So
18 there is not as much need to shift costs to the commercial
19 sector, but I think it's a good dynamic to keep in mind as
20 we're thinking through these health care costs.

21 And lastly, another point on that uninsured number, that
22 can certainly be a contributing factor to a hospital's costs
23 as more uninsured turn up in ERs, and often, those charges
24 roll to either to charity care or bad debt. Go ahead, Deb.
25 Actually, one more.

1 So trying to pull this all together, what do we think
2 this information tell us? Well overall, commercial premiums
3 and provider unit cost reimbursement are much higher than
4 comparison states. I think that's very clear. What's driving
5 it? Well, I think, in the MSA areas, it appears that
6 utilization is very efficient. So the culprit in the premiums
7 is the provider unit cost, for the most part.

8 Now what drives those costs? Well, we do see higher
9 costs than the comparison states, you know, quite a bit
10 higher. We also see higher hospital margins than the
11 comparison states, quite a bit higher.

12 I should make one more point on the hospital margins. I
13 don't believe I made it when we were going over that slide.
14 When we think of that delta on the margin -- I think it was
15 around seven percentage points when we looked at Alaska as a
16 whole, a little bit more when we just considered the
17 Anchorage, Fairbanks, and MatSu areas -- that's on the
18 hospital's overall business, and talking about the cost shift
19 again, the way they get there, as you saw in that slide, the
20 Medicare margin was negative. So you have much larger margins
21 on commercial business, negative margins on Medicare.
22 Medicaid is probably somewhere in between. But given that
23 we're seeing that seven-point delta on All Payer margin, you
24 know, it's not right to interpret and think, well if hospitals
25 reduced their commercial margin by seven points, they would be

1 at the average. It would be more like, if they reduced their
2 commercial margin by 14 points, if commercial is approximately
3 half of hospital payments. Just rough numbers, but I think
4 important to keep in mind.

5 So we think there is a different dynamic in these urban
6 areas versus the rest of state. In the rest of state, the
7 utilization is not as efficient, probably a big contributor
8 there is the delivery system is not as complete. Very high
9 provider operating costs. And on the hospital side, more
10 typical margin levels, as we see in other states. And as Ed
11 said, you know, on the physician side, we wish we had better
12 data to split out the unit cost versus the operating cost.
13 You know, an ideal thing would be looking at physician incomes
14 per relative value unit, which would also take into account
15 how many hours worked per year or how productive a physician -
16 - how much productivity a physician produces each year, but we
17 don't have that data. Next slide.

18 So just a couple points to keep in mind. You know, we've
19 been talking about hospital costs, the drivers behind those
20 costs. We haven't looked at -- we haven't tried to look at
21 quality measures, patient satisfaction. So I think, as a
22 Commission, of course, these are always very important to keep
23 in mind. We're not attempting to address those here. And
24 with that, I'd like to open it up for questions.

25 CHAIR HURLBURT: Let me start out. I'll take the

1 prerogative to have a comment and a question and then we'll
2 open to others. The comment is on slide 51 on the insurance
3 distribution. This is -- the numbers related to uninsured in
4 Alaska do jump around, and I believe, in this particular
5 report, it ignores the coverage that Alaska Native people
6 have. Alaska, as you know, has the highest percentage of
7 Native Americans of any state, just under 20%, and a number of
8 the reports for coverage do ignore coverage through the tribal
9 health system. And so when you adjust for that, normally, the
10 number of uninsured drop down to about 11%-12%, more like
11 other states. That's the comment.

12 The question has to do with the utilization area that you
13 talked about, and I'd like to hear your comment on that, where
14 Alaska has one of the youngest populations of any of the
15 states, and while our Medicare age population is growing
16 percentage-wise more rapidly than any other state, we're still
17 just a little over half in terms of percentage of our
18 population of 65 and over. And likewise, our commercial
19 population is a young commercial population so that, where a
20 35 or 40-year old generates a lot less hospital days, doctor
21 visits, and other things than a 60-year old does, and a 65-
22 year old generates a lot less than a 75 or 80-year old, the
23 age adjustments within those groupings of Medicare and
24 commercial make a big difference. To what extent is the age
25 distribution of those two population groups reflected in the

1 data?

2 MR. PICKERING: Great question. If we flip back to the
3 utilization slides, you know, there were two main studies.
4 The first was the MedPAC, and the second was the Milliman
5 Health Cost Guidelines. On the MedPAC study, the results are
6 adjusted both for age/sex, but also for health risk. So what
7 MedPAC has done is assigned the same risk score that is used
8 to risk adjust Medicare advantage payments. That's the HCC
9 risk score and that's assigned at the beneficiary level. So
10 those utilization results are normalized for the patient's
11 health risk, age/sex, and you know, diagnosis history.

12 The Milliman results are age/sex adjusted. So we do
13 normalize to a common age/sex distribution so that, when we
14 compare across states, it's a common age/sex distribution.
15 Now we don't go to the next step and do a health risk
16 adjustment, but you know, we do get to a common age/sex basis.

17 CHAIR HURLBURT: Thank you. Val?

18 COMMISSIONER DAVIDSON: So I noticed that -- I guess more
19 of a statement than a question -- the federal and tribal
20 hospitals weren't included. So there are, what, four military
21 hospitals. There's a VA hospital, Elmendorf, Eielson, and
22 Fort Wainwright, right? Four?

23 COMMISSIONER FRIEDRICHS: The VA and the Elmendorf
24 hospital are the same, so they're combined now.

25 COMMISSIONER DAVIDSON: So there are three.

1 COMMISSIONER FRIEDRICHS: And then there is only one up
2 in Fairbanks, so two military hospitals.

3 COMMISSIONER DAVIDSON: So then there are nine hospitals
4 that weren't included as a part of this study, right? So
5 that's nine plus 16 is, what, 25. So nine of 25 is what?
6 Does somebody have a calculator? So about 30. So basically,
7 this hospital information is, of the 60-some percent of the
8 hospitals surveyed, then you can draw your conclusions.

9 MR. PICKERING: Yeah (affirmative). And it's really a
10 lot of this information comes from the Medicare cost reports,
11 and those other hospitals don't file cost reports, or at
12 least, they're not included in the federal database of those
13 cost reports. And looking at this from a -- you know, while
14 we're interested in overall costs, the way we've really
15 tackled this component is to look at commercial health care
16 costs. So you know, from a commercial population, you know, I
17 don't think mainly you'd be using the tribal hospitals or the
18 military hospitals. So I agree that it's a slice, but I think
19 we have an important slice here.

20 COMMISSIONER DAVIDSON: And I guess the other question I
21 had was in terms of what that would do for the margin for the
22 hospitals statewide because it looked like your rural
23 hospitals had a margin of about 5%, and if an additional six
24 rural hospitals were included, what would that do? And six
25 out of the 25 hospitals is about 25%, so what would that do to

1 the overall statewide margin?

2 MR. PICKERING: Good question. Very tough to know
3 because we don't know what the margins are at those hospitals
4 or really the volume of those relative to the bigger
5 hospitals, but you know, if they had margins inline with those
6 other rural hospitals, it would bring that overall margin down
7 somewhat.

8 COMMISSIONER DAVIDSON: Yeah (affirmative). And I guess
9 I'm just -- really interesting information for the information
10 that you've gathered, but I guess I'm wondering, how
11 statistically valid it is for, basically, 60% of the hospitals
12 that were surveyed?

13 MR. PICKERING: Well again, I mean, I think it's -- you
14 know, we're focusing on that non-military, non-tribal slice
15 because that's the data we have.

16 COMMISSIONER DAVIDSON: So then you'd be okay with 60-
17 some percent of your payment for your survey of all of the
18 hospitals in Alaska, I guess, is sort of my parallel point.

19 MR. PICKERING: Well, I think we want to use as much high
20 quality data as we can and that's the data that's available,
21 but I also think it's very relevant data for evaluating the
22 commercial delivery system in Alaska. I mean, a lot of times,
23 I think you need to think of these delivery systems almost
24 distinctly. I mean, the VA has a very distinct delivery
25 system. The military has a very distinct delivery system. I

1 mean, sure, there is definitely interaction, and as a
2 Commission, I understand you need to consider all of those
3 components, but part of our -- most of our focus has been on
4 that commercial delivery system, in part, because that's the
5 data that's available.

6 COMMISSIONER DAVIDSON: And I guess my point is that, you
7 know, the tribal health system in rural Alaska is, effectively
8 and essentially and practically, the public health care
9 delivery system in rural Alaska because there is no other
10 presence. So if you are covered commercially by insurance or
11 you have no insurance -- or pick anybody. If you need
12 services in rural Alaska, that's where you would go, and I'm
13 just curious about why such a large segment of our hospital
14 population was excluded.

15 CHAIR HURLBURT: Val, basically, those hospitals do not
16 file reports from which this data is derived and that's their
17 choice. They could file them, if they wanted to. They could
18 file cost reports. Payers, the State, and Medicaid would
19 actually love it if they would, but they don't have to, and it
20 is extra work and it's not required. So that information
21 isn't made available. It's not that it was overlooking that.

22 When we had the earlier discussion and talked about it,
23 we went through all the hospitals in Alaska, and it was all
24 the non-public ones that were included. It would be helpful.
25 It would give a much better picture to get that information,

1 but it's not prepared as -- it's not filed. So our hands are
2 kind of tied on that.

3 COMMISSIONER DAVIDSON: Except we do have cost report
4 data. I mean, we do have that information. It's not in the
5 format that, perhaps, you're familiar with, but that
6 information is available. So I guess I'm trying to figure
7 out, is it because it was too hard? I'm just trying to figure
8 out why that information wasn't used, the information that is
9 available.

10 MR. PICKERING: Well, I'll address that from our
11 perspective. You know, we pulled these cost reports from the
12 data that CMS makes publicly available, and in that publicly
13 available data set, the reports are not there.

14 CHAIR HURLBURT: Noah?

15 MR. PICKERING: I guess, in a sense, that's a fair
16 statement. I mean, there is always -- you have to put a scope
17 around, you know, how far you're going to drill down into the
18 investigation.

19 COMMISSIONER ERICKSON: And I think that we just need to
20 be clear, and I'm sure it will be clear in the report from
21 Milliman. And as we interpret and incorporate this
22 information into our report and use it to form decisions about
23 recommendations, we just need to make sure that we're
24 remembering and understanding, if we're looking at issues
25 related to commercial coverage and the non-federal hospitals

1 and that piece of our system, how those recommendations are
2 going to play out.

3 COMMISSIONER DAVIDSON: Well, and I think we can do it a
4 lot more clearly by saying -- in statements where we talk
5 about hospital cost data and hospital utilization data, to
6 say, "out of the 63% of the hospitals surveyed da-da-da-da"
7 every time we say hospital information because, otherwise,
8 people will assume it's representative of all of the hospitals
9 in Alaska, and it's not.

10 COMMISSIONER DAVIDSON: I agree. I think it's also
11 important though to acknowledge the volume, too, of not the
12 percentage of the facilities, but the volume of utilization.

13 CHAIR HURLBURT: Yeah (affirmative), or another way to
14 put it, Val, might be it basically, surveys all the private-
15 sector hospitals in Alaska. It does not survey the public-
16 sector hospitals in Alaska. And I think, because the public-
17 sector hospitals do play such a large role, and as you pointed
18 out, that's what Bush health care is in Alaska, to a large
19 extent, noting that I agree with you. It would probably be
20 reasonable to do. Yeah (affirmative). Noah?

21 COMMISSIONER LAUFER: As usual, I have thoughts flying
22 all over the place. One of them, the Medicare thing is
23 interesting. For the purposes of the Commission, it would be
24 nice to have the future projection because, five years from
25 now, we're not going to be 8% Medicare. Just from my little

1 clinic, we've looked at demographics, and there is a tidal
2 wave of 64&3/4-year old people, all of whom want to continue
3 to see us.

4 Along Medicare, another big issue is that's not an evenly
5 spread burden. There are large sectors of Anchorage's
6 physician community that do not see Medicare at all, so that's
7 distributed.

8 And then the other thought, along what Val was saying, is
9 there is cost-shifting in Alaska that's different from
10 elsewhere and there is a big interplay between military,
11 Native, and private, and the one that comes to mind, for me,
12 is the Blood Bank. Providence is the primary purchaser of
13 blood in Alaska, at two-thirds of it, but pays a much higher
14 per unit cost because the patients who are Premera patients
15 who need a blood transfusion are paying for the O-negative
16 that's sitting out at some other village. Everyone in Alaska
17 pays the same for the unit cost of blood, but the burden of it
18 is paid by a provider. And if we get too tight on this and
19 Prov decides not to give blood from the Alaska Blood Bank and
20 do it from Puget Sound or something, all of a sudden, the
21 source of blood for blood transfusions all over the state is
22 no longer subsidized. So the cost is actually borne by the --
23 wherever the cost is shifted to private payers in Anchorage to
24 provide blood in Kivalina. It really -- I think it is hard to
25 imagine. You need to take them out on a tour to a Y/K village

1 and say, you know, we're talking about different things. It's
2 not Seattle. It's nothing like Seattle, you know. It's a
3 totally -- I don't know. It's hard to sift it out in the
4 data.

5 CHAIR HURLBURT: David and then Paul? Dave Morgan, did
6 you have your hand up?

7 COMMISSIONER MORGAN: No.

8 CHAIR HURLBURT: Oh, Wes? Yeah (affirmative).

9 COMMISSIONER MORGAN: (Indiscernible - away from mic)

10 COMMISSIONER KELLER: Yeah (affirmative). I think you
11 probably saw my hand. I was just wondering if you could
12 expand a little bit on your comment on the swing beds and the
13 critical access hospitals. I'm just really curious if that,
14 in your mind, reflects the fact that there are services
15 lacking for people in those beds in those communities or if it
16 has to do with, again, cost-shifting, Medicare, you know,
17 creative transfer of patients to get better Medicare rates?

18 MR. PICKERING: Yeah (affirmative). When you look not
19 just at Alaska hospitals but nationwide, we'll often see huge
20 negative margins on that swing bed SNF component of Medicare
21 care. So I don't think the big negative margins are unique to
22 Alaska at all. I think the volume of those services relative
23 to, you know, inpatient and outpatient services is probably a
24 lot higher in Alaska, in rural Alaska than in some other
25 states I've looked at, but yeah (affirmative). I don't think

1 the margins -- how negative those margins is surprising.

2 CHAIR HURLBURT: Paul?

3 COMMISSIONER FRIEDRICHS: Thank you, Mr. Chair. Going
4 back to the discussion about our more rural facilities, on
5 slides 25 and 28, you had mentioned that you were excluding
6 federal and tribal facilities, and I'm trying to understand.
7 So out of that then, which facilities did you include, if you
8 excluded the federal and tribal facilities and the non-MSA
9 areas?

10 MR. PICKERING: (Indiscernible - away from mic)

11 COMMISSIONER FRIEDRICHS: Understood. I'm just -- so
12 Ketchikan, Kenai.....

13 MR. PICKERING: Those would all be in there.

14 COMMISSIONER FRIEDRICHS: So.....

15 CHAIR HURLBURT: Yeah (affirmative). We went through the
16 list, and it included Cordova. It included Petersburg. It
17 included Wrangell.

18 COMMISSIONER FRIEDRICHS: All right.

19 CHAIR HURLBURT: Really, it included all of the non-
20 tribal, non-federal hospitals in the state. It did not
21 include St. Elias as a non-acute hospital.

22 COMMISSIONER FRIEDRICHS: Thank you.

23 MR. JHU: And in our final report, we will have a listing
24 of the facilities, just to clarify what's been included.

25 COMMISSIONER FRIEDRICHS: Thank you. And then my

1 colleague, Dr. Laufer, had brought up a point earlier. I
2 think most of us have struggled with recruiting into the area.
3 What I think I'm taking away from your comments is that, of
4 those health care providers who are employed in this area,
5 they have relatively acceptable margins or higher margins than
6 in comparison states there, but this analysis does not speak
7 to unfilled positions in any way as far as I could tell; is
8 that correct?

9 MR. JHU: You're right. Yeah (affirmative). And
10 certainly, you know, back to -- the salary surveys are, by
11 definition, the salaries of those who have been employed. We
12 didn't look at that. The one piece that we attempted to look
13 at to try to help that was looking at the medically
14 underserved areas as far as the primary care physician
15 shortages, and you know, what we did find was that the
16 relative level of medically underserved areas wasn't
17 significantly higher in Alaska than other areas, but that
18 focus was primarily on the primary care physicians. At least
19 anecdotally, we have heard that the relative reimbursement and
20 some of the shortages do tend to be more exacerbated for some
21 of the specialty areas as compared to primary care.

22 COMMISSIONER FRIEDRICHS: And that leads me to kind of
23 the gist of this part of the question. We've had the American
24 College of Physicians out here. We've had the American
25 Academy of Family Practitioners and others in the past speak

1 to their perception of a shortage of primary care physicians.
2 We, I believe if I remember a prior presentation, have 12
3 internists in the metro area who see any Medicare patients --
4 I think that was the right number -- with waiting lists for
5 Medicare patients to get in. Could you help me reconcile the
6 perception from those other studies, and at least, the
7 anecdotal reports of an inability to obtain primary care with
8 the data that you've presented today?

9 MR. JHU: I think, in part, some of that is -- as we saw,
10 the primary care shortage isn't really restricted to Alaska.
11 I'm guessing some of those bodies that you're talking to are
12 probably having some of the same conversations with a number
13 of other areas nationwide. So I think, at least in part, you
14 know, the discussion and the whole concept of a primary care
15 shortage is something that isn't really restricted to here,
16 and as a result, as we're comparing Alaska to the other
17 states, you know, what we're saying is that there is,
18 relatively speaking, no more of a shortage here than there is
19 elsewhere. At the same time, that's certainly, by no means,
20 intended to, you know, diminish the fact that there is that
21 12% number as far as 12% of patients -- or 12% of the
22 population that is in a medically underserved area.

23 CHAIR HURLBURT: On the comparative states, the medical
24 school states, Oregon and Washington, are more richly supplied
25 with physicians than we are. The other main comparative

1 state, Idaho, has a less physician population, lower than
2 Alaska does.

3 COMMISSIONER FRIEDRICHS: And I guess I would just ask,
4 as we, as a Commission, work on this report -- and I think
5 going back to Val's point, words matter -- if we were, for
6 example, to say that we are less -- we are about as -- we are
7 no worse underserved than other states, that doesn't capture
8 the level of complexity of the discussion of primary care
9 right now in that there is a United States-wide shortage of
10 primary care physicians, and I think the way you said it may
11 be more helpful than some of the discussions that we are no
12 worse off than other states, perhaps?

13 CHAIR HURLBURT: Pat? Go ahead.

14 MR. PICKERING: Can I just add one comment to that
15 discussion? The other thing to consider on the Medicare front
16 is, you know, how many of those primary care docs are
17 accepting new Medicare patients. So there may be less of a
18 shortage for commercial payers and more of a shortage for
19 Medicare beneficiaries.

20 CHAIR HURLBURT: Pat and then Noah?

21 COMMISSIONER BRANCO: Thanks very much. I have a
22 statement or an explanation and then a question, and they're
23 separate from each other.

24 The first one is on your summary or your conclusion page,
25 and it's not up there, on the rest of the state, and this is

1 the explanation piece. Your points are correct here. Typical
2 hospital margins, in comparison with the rest of the nation,
3 are very high provider operating costs and poorer efficiency
4 than the MSA. The explanation is -- and one explanation is
5 two-fold.

6 Number one, in order to attract physicians, primary care
7 and specialists, to a community where there isn't a population
8 base to support those is very challenging and so, with
9 orthopedic surgeons, I have to hire two. In our community, I
10 employ all the physicians with the exception of one. I have
11 to hire two just to cover call. The volume of clinical
12 services in the community is about one-and-a-quarter, but to
13 provide any measurable lifestyle, I'm forced into
14 inefficiency, and this is true throughout much of the state.
15 It's not a great mix. There are great charts that show you
16 what's the most efficient model per population of which
17 primary care and specialists you have.

18 The other inefficiency is much of our state is tourist-
19 bound and so, while my 8,000 person population community year-
20 round, in the summer, I have a million visitors and 400,000
21 crew members on ships. It forces my hospital to be larger
22 than it appears on paper 12 months of the year, but for five
23 months of the year, it's got to be profoundly capable. So I
24 try to put those all in balance. This is not atypical for
25 many of the communities, including the MSA. This is a largely

1 tourist-driven state and we accommodate that swell in
2 population as a result. Okay. That's my explanation on that.

3 My question is, really early on -- and I'm going to ask
4 to force feed an answer into the summary -- you said quietly,
5 we can't explain why the drivers don't account for price or
6 something. It was very quick, and I wrote it down just so I
7 wouldn't miss it. In summary, what are the key drivers that
8 are affecting the price of care in the state of Alaska, from
9 your perspective and your study? And you can refer back to
10 the summary slide.

11 MR. PICKERING: That's a good question. I don't remember
12 that comment, but let me answer the question. You know, I
13 think a lot of the key drivers are these. If you flip to --
14 maybe you could put it up, Deb -- slide ten, which is our
15 roadmap slide, you know, as we drilled into both professional
16 and hospital costs, you know, medical salaries, the BLS data
17 showed the nursing about 10% higher. Our survey data showed
18 it about 2% higher. So you know, we think that's a
19 contributor. The cost of living looked to be about maybe 20%
20 higher than the comparison states. We think that's a
21 contributor. The discount information, it looks, to us, that,
22 especially on a physician front, the physicians have pricing
23 power relative to -- or with commercial payers. We think
24 that's a big contributor. On the hospital operating costs, we
25 do agree that, in the rural communities, you have these issues

1 of inefficiency. I think that's clear. It's tough for us to
2 get a specific metric to look at that and quantify it, but
3 we're not doubting that that's true, you know, and maybe part
4 of that even is in the staffing. Like you said, I mean,
5 you've talked to doctors on-call, but maybe also nurses. You
6 may have higher staffing to cover those swell periods, and
7 they may be seen in our higher staffing ratios in Alaska than
8 elsewhere. And then, you know, explicitly on hospitals in the
9 more urban areas, we're able to quantify we think that margin
10 is also a driver of the unit cost.

11 COMMISSIONER BRANCO: Thank you. One quick comment, and
12 I've been unsuccessful so far in trying to partner with Palm
13 Springs hospitals to share staff. They swell in the winter
14 with their tourist season, and we swell in the summer. So
15 far, I haven't managed to get that, especially for
16 ultrasonographers.

17 CHAIR HURLBURT: Next will be Noah and then Keith and
18 then I would like to invite, particularly, the five folks who
19 have not made a comment or a question yet to think of a
20 comment or a question. So Noah and then Keith?

21 COMMISSIONER LAUFER: Just real quick, again from the
22 primary care perspective, you know, a lot of what the
23 Commission is saying is, you know, primary care needs to be
24 stronger. We need patient-centered medical homes. We need
25 EMRs and all that. All of those translate into higher

1 utilization of primary care, less efficiency actually, fewer
2 patients per doctor, because we're looking for a higher
3 intensity of care. Nationally, the supply is shrinking. The
4 number of residencies is shrinking. The number of U.S. grads
5 going into primary care is shrinking, and we are going to be
6 in a more and more competitive race to attract these people.
7 And you know, you can't do that, and at the same time, say
8 we're going to pay them less because other states are going to
9 pay them more and we're going to be screwed.

10 There are answers, and I think, for our model, we're
11 going to have to go to mid-levels, but you know, there is a
12 cost to that as well, and there is a cost even to the payers
13 because it tends to be not as efficient. So you know, if an
14 awful lot of our recommendation is towards these ideas, we
15 have to support it.

16 COMMISSIONER CAMPBELL: Being around this medical
17 community for 40 years, this is all intuitive and those
18 numbers haven't moved in -- most of them haven't moved in all
19 of my time around here, quite frankly, but that be as it may,
20 you see what's happening here. And this is purely cynical on
21 my part. We're going to see everybody whose ox is going to be
22 gored start to rationalize this report. So we may -- I don't
23 know whether that was smart or not to do it, but it's just a
24 pure fact. If medicine is going to become, as the Commission
25 has told us at the last meeting, basically a zero sum game

1 with money into the system, particularly on the Medicaid side
2 and that's a big driver in the state, then we're going to see
3 a lot more of this utilization or rationalization. We're
4 going to see probably some blood flow. I think an
5 illustration of that is my friend, Colonel Friedrichs, is a
6 urologist by trade, and nationally with the new
7 recommendations on PSAs, you see the papers and the collision
8 that's going to happen there because those kind of
9 recommendations, as with breast cancer a year or two ago, are
10 going to get right in somebody's pocket. And so whoever is
11 going to be refereeing this next 15 years is going to have
12 lots and lots of fun. Enough said.

13 CHAIR HURLBURT: Thank you. How about any of -- Emily?
14 Thank you.

15 COMMISSIONER ENNIS: I was interested in seeing the
16 negative margin relative to Medicare, not only in Alaska but
17 everywhere. And knowing that Alaska has some unique
18 circumstances in the projected growth of our aging population,
19 some say -- some reports have said three times the growth,
20 there is going to be a bigger-than-average swell in the
21 reimbursement in Medicare. You spoke of the cost-shifting to
22 the other commercial payers to help that right now. That's
23 how hospitals are breaking even, but what is the breaking
24 point? Have we looked at a point in time, if we're looking at
25 these projected numbers over the next 20 years, in which, you

1 know, we really go beyond the breaking point? I think it's
2 just something -- I think it's more of a comment, unless you
3 have an answer to that, but that, you know, how far can we
4 support and subsidize the Medicare payment?

5 MR. PICKERING: I think that's a great comment. I don't
6 have an answer. I have something to add though. The other
7 big force you're going to see is, with PPACA in 2014, the
8 expansion of the Medicaid population. So not only does your
9 Medicare population grow, your Medicaid population is going to
10 grow. Your commercial population may shrink somewhat. So a
11 lot of that Medicaid growth may come from uninsured, which
12 would be good, but you know, some of it will probably come
13 from commercial. So I think, from a provider perspective who
14 had been balancing their books, or you know, making the
15 payments from commercial offset, these public payers, it's
16 going to be a more difficult balancing act. So I don't know
17 the answer of, you know, when it breaks, when one side of the
18 scale falls off, but you know, the Medicaid growth is another
19 important consideration in that.

20 COMMISSIONER ENNIS: Thank you.

21 CHAIR HURLBURT: Keith again?

22 COMMISSIONER CAMPBELL: In this matter of efficiency in
23 resource use and things of that nature, having a lack of
24 certain provider classes, does this lead to some sort of
25 efficiency or resource use?

1 MR. PICKERING: Good question. On the MedPAC study, that
2 is all Medicare beneficiaries. So you know, that's whatever
3 providers those Medicare beneficiaries are using. You folks
4 know better than I how much they'll use the tribal or rural
5 areas. So you know, the MedPAC study would include any
6 provider that Medicare beneficiaries use. To the extent
7 though that the tribal and federal hospitals aren't serving
8 that population, yeah (affirmative); we haven't really been
9 able to assess the efficiency at that slice of providers. So
10 you know, would we see the same type of utilization efficiency
11 at this slice of tribal and federal hospitals? I don't have
12 an answer for that.

13 COMMISSIONER CAMPBELL: Well, my question isn't even
14 geared to that particular thing -- is to the just general
15 overall efficiency being forced on medical community by having
16 a lack of resources available to take care of those people?

17 MR. JHU: Well, I think, from that standpoint, certainly,
18 there is the short-term versus long-term trade-offs, I think,
19 that are recognized as far as -- or at least, you know, being
20 pushed forward now with some of the movements towards some of
21 the medical homes, et cetera, of, you know, getting that
22 primary care, and hopefully in doing so, avoiding either long-
23 term conditions or the exacerbation of some of those
24 conditions, but you know, short of that, the immediate
25 potential benefits as far as if you can't actually see a

1 provider, then you won't, and obviously, that utilization is
2 not going to be there. Presumably, something, like that, over
3 the long-term would lead to other issues as far as, again,
4 worsening of the health status of the population, et cetera,
5 such that I wouldn't think that you would see long-term
6 savings as far as a utilization study from a lack of
7 providers.

8 MR. PICKERING: I would add, you know, in some studies
9 nationwide, you do see results that, you know, the total
10 utilization is directly proportional to the total number of a
11 certain type of specialists in the community, and I would
12 agree with you that probably the relative sparsity of
13 specialists here does contribute to the lower utilization.

14 CHAIR HURLBURT: David?

15 COMMISSIONER MORGAN: Oh, if I have to. I guess one
16 comment I'd like to make is tribal health does file a what
17 they call a Method E Cost Report. It's not the same type of
18 cost report that private or non-profit general hospitals file,
19 which is a 2552 Medicare Cost Report. To take those five cost
20 reports, six cost reports that are filed would take some
21 significant analysis. What I have seen done, what are
22 checklists, what's the difference between the two cost reports
23 and what would you have to do to manipulate -- all the data is
24 there, but there would be significant manipulation to come up
25 with what you would need. Instead of looking at the number of

1 hospitals, I agree you should look at the number of patient
2 days, and it's probably smaller than the strict number of
3 counting buildings.

4 I guess my question would be -- that's just a point of
5 interest. My question is, when I looked at the detailed data,
6 I actually -- that shows you how boring my life is. I
7 actually looked at -- down to your HCPCS and with the
8 modifiers even, looking at the data. What I was struck with -
9 - because I spent a third of my career in the Lower 48 -- was
10 there was some difference. This is not a question of whose ox
11 is getting gored. This is more of a statistical issue. It
12 may not be an issue, but the type of DRGs or HCPCS seem to be
13 slightly different than what I was looking at -- my mix.

14 Now I don't think that's a justification necessarily of
15 explaining away differentials in cost or even price, but it
16 did show a pattern that matched our population pattern. And
17 if you think about younger people -- and in resource states,
18 you tend to see a slightly different type of DRG. You do see
19 a slightly different HCPCS and that's pretty obvious. But the
20 real question is, in my own mind, how do you factor -- like my
21 colleague at the end of the table, how do you factor that
22 through to workforce development? How do you factor that
23 through even to trauma, you know? We probably, like a lot of
24 resource states, have, you know, crab pots falling on people,
25 and I've had to Medevac those out. Those are pretty

1 significant injuries. You have a lot of military, and when
2 someone messes up in the military, it's usually not three
3 stitches. It's probably a whole lot of stuff. So I mean, I
4 don't think I'm giving an explanation of why the cost, why the
5 price is different. It's just that some of our activities are
6 different, and in my own mind, I haven't reconciled that, let
7 alone, I think if anybody can, it's the guys at the end of the
8 table. Some of that data -- I think this is good. I actually
9 -- this is the first time -- I guess I haven't been in for 40
10 years. It's the first time I've actually seen it done this
11 way up here, and I think it's very helpful and I think it will
12 help us do some things or make some recommendations.

13 I would suggest that, if you really wanted a little more
14 data on cost of living, one packet after ours from the
15 Hospital Association has a little more detail on differential
16 costs between areas, especially rural and urban, and the
17 economics -- the trends put out by our Labor department, which
18 you can go online and get -- and we've even handed them out
19 here -- did have some information detailing differentials
20 between cost of living, between rural and urban, basically
21 aligned along the school district questions, which hey, you
22 know, a little plagiarism isn't bad if it saves us some money
23 here.

24 But overall, I would give you high marks, and yeah
25 (affirmative), as I've said a couple of times in other forums,

1 some of us may have to have someone start our cars for us at
2 the end of this, but the truth is the truth. The cost is the
3 cost, and we're just going to have to face it and accept it
4 and now manage our way through it. So for once, I'm -- you
5 know, three minutes, five minutes is all you're going to get
6 out of me.

7 CHAIR HURLBURT: Thank you. Larry?

8 COMMISSIONER STINSON: This is more of a comment than a
9 question, but I thought Patrick had a good point. We're going
10 to have hospitals in places that maybe other states won't have
11 hospitals, and we need hospitals there, and we have to have
12 providers there. And then there are the idiosyncracies of
13 that. You know, I'm sure other states have considerations,
14 like that.

15 There are several exclusions to your data, too. I think
16 it's still a good overview, but there are significant
17 exclusions, too. I think, coming away from this, just
18 thinking of it in general terms, we knew we had a problem. We
19 know we have a problem with physician distribution. We know
20 we have a problem with providing health care in a trauma
21 system in a state that is as large as a third of the United
22 States. We know all that, I think, and there were no
23 recommendations about how to control these costs which, I
24 don't think, was part of the study. So eventually, we're
25 going to get back down to what we were talking about with the

1 medical home model and doing evidence-based care, trying to --
2 knowing that we have to provide this care to this community,
3 to this state, we still have to figure out a way to do it more
4 efficiently, and it sounds like we're doing a lot of things,
5 from what you presented today, actually better than maybe what
6 we thought, but again, that's not including all of the
7 participants and that might be difficult to get all that
8 information. I don't know. I would defer to the people who
9 do that on a more regular basis, but we knew we had a problem
10 going in. You guys, I think, presented the problem well. We
11 still have to figure out a way to deal with it. That's just a
12 comment.

13 CHAIR HURLBURT: Yes. Well said. Jeff or Allen,
14 anything? Okay. Paul?

15 COMMISSIONER FRIEDRICHS: Thanks. So if I could go back
16 to being a South Louisiana public school grad, making sure I
17 understand exactly what you said, what I jotted down at the
18 end of all of this was that medical salaries here in Alaska
19 are about 2%-10% higher than comparison states, which were
20 higher than medical salaries in the rest of the United States.
21 Was that a correct understanding?

22 MR. JHU: Yeah (affirmative). I think that was about 2%
23 to 10%. To be honest, I'm digging back through my -- Deb,
24 let's see if you can pull up that second slide, the BLS slide,
25 itself, I think had that information there.

1 MR. PICKERING: Yeah (affirmative). I think it's slide
2 41.

3 MR. JHU: Thanks. I'm sorting through the package of
4 papers here at this point, myself.

5 MR. PICKERING: It looks like on, you know, this slide, I
6 would agree with what you said. The BLS study, if we focus on
7 registered nurses, which is the biggest category of these, the
8 BLS shows it 10% higher than the comparison states. I guess
9 we did not pull nationwide in here, so I'm not sure how
10 nationwide compares to the comparison states, but we could
11 pull that pretty easily. And then the salary survey, you were
12 right, showed about a 2% differential on nurses.

13 COMMISSIONER FRIEDRICHS: And this only reflects, as we
14 discussed before, the salaries of those who we have been able
15 to entice to come here to Alaska.

16 MR. PICKERING: Right. Right.

17 COMMISSIONER FRIEDRICHS: So this doesn't reflect an
18 unmet need in anyway.

19 MR. JHU: It is current salaries.

20 COMMISSIONER FRIEDRICHS: And then the second takeaway
21 that I had was that the higher cost of living -- you had
22 mentioned anywhere from 15%-20% -- contributes to the overall
23 higher cost of health care here.

24 Then the third key point that I heard you mention was
25 that -- or notable point that you mentioned was low physician

1 discounts contribute to the higher cost of health care here in
2 Alaska relative to comparison states and national averages.
3 Is that a correct understanding on that one?

4 MR. JHU: Yes. It certainly -- it's an indication of the
5 -- again the relative power in certain markets. There are
6 certain markets where the insurers, effectively, can dictate
7 the prices that they're going to pay, and the physicians are
8 forced to accept it. There are other markets where the
9 physicians can, effectively, dictate what they are expecting
10 to be reimbursed and the insurers are forced to pay it. I'd
11 say Alaska is probably moving more towards that second end.

12 COMMISSIONER FRIEDRICHS: And then you mentioned that the
13 urban hospitals, in general, were relatively efficient in
14 comparison to the comparison states and the U.S. averages in
15 our rural hospitals appear to be less efficient, based on the
16 data that you had collected. Obviously, there are many
17 discussions about why that is. I just want to make sure I
18 understand the conclusions.

19 And then the last point that, I think, was your last
20 conclusion of all of this was that our urban hospitals
21 reported a significantly higher margin than hospitals either
22 in the non-MSA areas here in Alaska or the comparison states
23 that you looked at were in comparison to the United States.
24 Is that a correct understanding also?

25 MR. JHU: That's correct, but at the same time, as John

1 noted, even within each of those categories, there are wide
2 ranges of margins, such that, you know, within even the urban
3 hospitals in Alaska, there is a wide range of margins, and
4 certainly if we were to look at the comparison states, we'd
5 see some fairly disparate margins also, both from commercial
6 and Medicare payers.

7 COMMISSIONER FRIEDRICHS: And then if I could, just to
8 tease out one other part of your data -- and unlike Dave, I
9 have not had the luxury or the time to go through the HCPCS
10 and everything else. When you looked at all of this, did you
11 look at for-profit and non-profit facilities in an identical
12 fashion or was there any delineation between for-profit and
13 not-for-profit margins in the analysis that you did on
14 hospital margins?

15 MR. PICKERING: No. We didn't split it between for-
16 profit and not-for-profit. We do have, you know, these
17 results by hospital, so we can roll it up really easily any
18 way you would like to see it. So we could have that.

19 Just following up on that, you may know more than me on
20 this, but of the four hospitals that were in the Anchorage,
21 Fairbanks, MatSu urban area, two of them had very high margins
22 and two had more typical margins.

23 COMMISSIONER MORGAN: When you -- I printed them out if
24 you, you know, want to look at them. They didn't break them
25 out by hospital, but they did break them out by payer type.

1 So you can look at Medicaid versus Medicare, TRICARE. Even
2 some of the areas have VA. And yeah (affirmative), it is kind
3 of a bizarre world in some ways. There is not a whole lot of
4 deviation, but there is some, and I think it goes back to our
5 old analysis at HFMA where, you know, you'd put the square up
6 on there would be four parts. One is your high volume/high
7 profit. One square is your low volume/high profit, and the
8 square that's high volume and losers, and your high volume and
9 you don't know kind of stuff. And then you sort of manage to
10 do that. I can't tell if that's going on, mainly because, now
11 that I'm approaching 60, I just can't do it in my mind
12 anymore, but if you look at the printouts, it does -- there
13 are some differences, depending on the payer group, and I
14 don't know if that's cost-shifting or simply the different
15 types of utilization by each code, and it's probably a mixture
16 of both. If we employ the Fairbanks super computer, we might
17 be able to come up with that. But if you've got -- at the
18 break or sometime, I'll let you borrow -- I mean, you can just
19 pick out two or three and kind of look.

20 COMMISSIONER FRIEDRICHS: May I? Thank you. I'm always
21 beholden to folks who offer me a six-inch stack of printouts
22 to review. I very much appreciate your willingness to share
23 there. I do think the variance though remains an interesting
24 question for us to understand. I mean, as part of our charter
25 when I go back and look at what we were asked to address from

1 the standpoint of efficiency, enhanced market forces, and
2 reducing overall health care costs, understanding that
3 variance within margins or within provider discounts,
4 certainly are going to be interesting areas for us to
5 understand better as we make recommendations. So thank you to
6 my kind colleague for that.

7 CHAIR HURLBURT: David, these Excel sheets you have were
8 from the first reports. There will be some subsequently, too.
9 Yeah (affirmative). Pat?

10 COMMISSIONER BRANCO: I want to add a point of emphasis
11 to Keith's comments. This is the time for analyzing
12 everything that we're doing in the delivery of care, how to
13 control our costs, how to be more efficient and responsive to
14 our patients and our communities. And I would be remiss if I
15 didn't point out that what we're doing here with the pricing
16 study and the cost driver analysis is only looking at one
17 small section of the health care cost impact. This is
18 hospitals, hospitals only, and so as I raise points and bang
19 the microphone around, it's really to focus on that piece in
20 preparation for all of the oxen that are lining up and will
21 need to line up as we get a handle on all the health care
22 costs in this state. So everybody standby. These are really
23 appropriate comments. These are the times to really strip it
24 down and look at what we're doing and get past making excuses
25 for why we do what we do.

1 CHAIR HURLBURT: Any other questions or comments? Ed and
2 John, thank you very much for your, obviously, non-stimulating
3 report. So we appreciate the work that you've done, and we'll
4 look forward to the final report on that. I think this is
5 very helpful to us. Deb?

6 COMMISSIONER ERICKSON: I think we should just take an
7 early break. Come back in 15 minutes.

8 CHAIR HURLBURT: Let's go ahead and break and come back
9 at quarter past. Thank you.

10 9:59:10

11 (Off record)

12 (On record)

13 10:20:39

14 CHAIR HURLBURT: Thanks, everybody, for your
15 participation in the first discussion. We want to talk about
16 -- as a follow-on now on the Alaska Health Workforce, there
17 has been a study that's been going on, quite a bit of work
18 done over some time. We've all seen some of the documents
19 that have been published and have come out related to Alaska
20 Health Workforce. We have Jan Harris, Vice Provost from
21 Health Programs at UAA, Karen Perdue, formerly Vice President
22 in Fairbanks with the Health Programs for UAA and CEO of
23 ASHNHA now, and Delisa Culpepper, COO for the Alaska Mental
24 Health Trust will be presenting the Action Plan from the
25 Workforce Coalition to us. Thank you, all, for coming, and

1 maybe I'll kind of offer the same guideline. If there are
2 some questions that come up during the presentation, I'm sure
3 they would welcome and respond to the questions, but for the
4 most part, if we could kind of let you go through your
5 presentations and then have our discussion afterwards, I think
6 we'll have plenty of time on this. So Karen, are you going to
7 start? Thank you.

8 MS. PERDUE: Well, thank you, Mr. Chair. We -- it seems
9 like we had good timing on the part of the organizers of the
10 meeting to discuss workforce, since cost of labor seems to be,
11 at least on the hospital side, about 60% of every -- 60 cents
12 of every dollar spent is in labor. So how can we look forward
13 and efficiently manage a major cost center for hospitals,
14 nursing homes, and other health care entities? I think that's
15 why we're in the game. That's why ASHNHA's in the game.
16 We've been in the game for many years, and our board just
17 endorsed this implementation plan that we're going to go over
18 with you today at our meeting in Ketchikan. So we're onboard
19 to try to make some difference in some of the knotty, age-old
20 problems.

21 I wanted to start with the first slide. That's not my
22 first slide, but is that the first slide? All right. Good.
23 We missed our Greco Roman image. I'm sure it'll be there
24 somewhere. There is it. See. We're trying to evoke the gods
25 and try to get some wisdom on this problem because it's

1 challenging, and the reason it's challenging is there are over
2 80 health professions, you know, that can work on. And my
3 experience -- Dr. Hurlburt mentioned I was at the University
4 of Alaska, Associate Vice President there working on Health
5 Care Academic Development -- is that, if you start working in
6 one profession, then another profession asks you well, why
7 aren't you working in this profession?

8 So I think the idea of this coalition was let's get
9 everyone in the room who is willing to come. Let's sit down,
10 and let's try to roll up our sleeves and figure out what we
11 can actually get done in the next five years. Now that
12 doesn't mean maybe we're always addressing the highest need,
13 but we're addressing the highest need that we can get
14 something done on. So we've sort of worked our way through
15 that process and that's you're going to see today, the
16 occupational priorities that we want to have a focus on, some
17 system changes that we really think we need, and how do we
18 keep ourselves accountable in the process. Next slide. Go
19 back to the other slide then.

20 So we wanted to go back and remind you of your words.
21 You've been looking at this issue for some period of time.
22 Even when the Commission was not as many members as it is
23 today, you started working on workforce, so here are some of
24 the things you said. Keep on it. Keep tracking it. Keep
25 going, Deb. So we are.

1 What are we? We are a public-private partnership. We
2 are not a formal entity. We come together on a voluntary
3 basis to develop, implement, and support a statewide approach.
4 So we're -- go to the next one. Go to the next.

5 So here's the Action Agenda. So last year, we did a big
6 long report, and it had -- it laid out our top priorities.
7 We've now taken those top priorities and we've written
8 something about each one and what we actually think needs to
9 be done. So we're going to go over that with you today.

10 So these are the occupational priority areas. Primary
11 care providers, which, no surprise to you, that includes
12 physicians and nurse practitioners. We did not recommend
13 improvements at this point in the PA programs because there
14 have been some good progress made in that area. Direct care
15 workers. This is the 6,000 to 7,000 people who work in our
16 direct service component, you know, minimally paid, sometimes
17 100% turnover in some agencies, maybe even 120% turnover as
18 they jump from employer-to-employer, so they can get 20 cents
19 an hour more and make their -- you know, make their hours and
20 so on. So how do we deliver quality care? How does Emily
21 deliver quality care and improve that workforce? That is a
22 direct -- that is a bottom line question for her and many
23 others. Behavioral health clinicians. This includes
24 psychiatrists, but it also includes other behavioral health
25 professionals in the state. Physical therapists. We have no

1 plan. We have no strategy for physical therapy in Alaska. We
2 need one. We are working on one. So we are probably down to
3 one of the few states in the country that does not have either
4 a physical therapy school or a connection to an accredited
5 program. Nursing. There has been a large increase in the
6 production of Bachelor's and Associate prepared nurses, but
7 specialty nursing is very woefully short. We have some plans
8 in specialty nursing. This is driving up the cost of care in
9 hospitals. As we don't have peri-operative or critical care
10 nurses or others, we are importing that labor force and paying
11 a premium for it. And then pharmacy. We are, again, the only
12 state in the union that does have a pharmacy school, and we do
13 not have a pharmacy -- we are beginning to get, but we do not
14 have a pharmacy strategy. So our students, our Alaska
15 students are not entering pharmacy school at a very high rate,
16 and if they are, they're not returning. So those are the
17 priority areas, and we're going go through a little bit more
18 detail on each of those for you.

19 In terms of system capacity and change, just the
20 highlights on these because, again, there will be some more
21 detail. We need a loan repayment approach, an incentive
22 approach. There is a piece of legislation and other efforts
23 going on that we want your support for.

24 Professional development is really important because
25 there is this concept of the hole in the bucket. I mean, you

1 can create a lot of supply, but if the burnout is high and the
2 retention is low, then you've got a hole in the bucket. So
3 what do we do about professional development?

4 Aligning regulatory policies that impact the health
5 workforce. There are some policy papers that you've seen
6 about licensing, background checks. Those are examples of
7 regulatory areas that could continue to need some improvement.

8 The pipeline of kids. How do we get kids attracted? You
9 know, kids are being recruited by engineering schools.
10 They're being recruited by, you know, other professions,
11 construction academies, et cetera. You know, how does health
12 care stand in line and actually go to the front of the line to
13 get the talented kids, so that they will stay and practice
14 here?

15 And then we are always going to be an importer, we
16 believe, of health workforce. We're never -- I shouldn't say
17 never, but in the next -- certainly in the period of time of
18 this plan and probably for the decades to come, we're going to
19 need to recruit specialty providers. So do we have the most
20 efficient recruiting system, particularly for those smaller
21 entities, community hospitals, other entities that just cannot
22 recreate the recruiting structure each and every time they
23 have a vacancy? And then data. So that, I think, is my
24 handoff now to Delisa.

25 MS. CULPEPPER: We're going to talk very quickly a little

1 bit about the structure of the Coalition. One of the things
2 you're going to notice this year from when we were here last
3 year -- last December, I think, Jan and I came to talk -- is,
4 at that time, we had two different health workforce planning
5 efforts going on. One of them that had been going on for a
6 while was a partnership between the DHSS, the Trust, and the
7 University, and we had been working on our health workforce
8 focus area for about four years. And the other was the
9 Coalition that had just started up and was planning, and the
10 Trust was part of that and so was DHSS. And this year, we
11 have executed a merger and are using our resources that we
12 were using to staff our Trust focus area in partnership with
13 DHSS and the University to help staff the larger coalition
14 now. And so this leadership of the Coalition has been formed,
15 a combination of our prior partners with the Trust and the
16 Coalition leaders, government, and industry, as you see, and I
17 won't read all those through. Next.

18 We have also a larger group of Coalition members that are
19 industry, state people, and people from the education and
20 federal systems. Deb, next.

21 And then just a reminder that, prior to 2009, our focus
22 area did work, as I just mentioned, and we were working on
23 primarily the direct service workers, psychiatrists, advanced
24 clinical degrees, and system change things. We have been
25 fairly successful at engaging the Department of Labor and

1 working on some recruitment and other things, and we're
2 bringing that over to work with the Coalition now.

3 Just some quick -- a reminder of the Coalition starting a
4 couple years ago and doing the actual bigger plan that you've
5 seen. We tried to keep the look the same, so that you guys
6 would be able to associate the new Action Agenda with the
7 plan, and we've gone, in the last two years, at looking at
8 what were all the occupations down to doing outreach to
9 constituency groups and looking at what can we do about some
10 of these and choosing what we referred to earlier as priority
11 occupations. Okay, Deb.

12 And with the 15 occupational groups, we went down to, I
13 think, six priority occupations and then started working on
14 strategies, which is what you see before you today, the Action
15 Agenda, that has strategies around engagement, training,
16 recruitment, and retaining workforce.

17 We continue to work with consultants and other things.
18 We did have a HRSA grant for a year-and-a-half that Jan is
19 going to talk about in a minute that helped us look at data
20 and try and establish new data sources that we could track
21 over time, looking at health workforce and working with the
22 Department of Labor and we'll talk about those results and
23 things. And then now we're at the next phase of looking at
24 implementing our Action Agenda and we'll be going out and
25 talking to many groups, like yourselves, talking about how can

1 everybody get involved. We need people in different
2 workgroups to help implement this Action Agenda now. It's not
3 all about planning. It's going to be about, can we, over the
4 next few years -- and I handed out a sheet right before that
5 you'll see is a list of all of our objectives that are in the
6 Action Agenda that we -- a work tool we're going to be using
7 to say who is responsible and how are we making progress on
8 these, on each one of them. And so we're in the process of
9 forming workgroups. We have some of them already up and
10 running that had been working with our focus area for several
11 years, so we're well into implementation on some things. Some
12 things are going to be brand new, and some things are kind of
13 in the middle. So we'll talk about those more in a minute.

14 MS. HARRIS: So we want to spend a little time looking a
15 little more deeply at data and what we've discovered in
16 working together over the past year. Really in order to plan
17 for the future, we have to have a clear picture of our current
18 health workforce and the ability to predict then what our
19 needs are in the future.

20 We have many types of data available, we've discovered,
21 but the picture is incomplete, and each one has its own
22 difficulties and limitations. I've compared trying to figure
23 this out as looking into a cracked crystal ball or having a
24 tattered patchwork quilt that we have pieces, but the picture
25 isn't really formed yet. So we've been working together on

1 identifying gaps and developing a more comprehensive and
2 integrated set of data.

3 As Delisa mentioned, we had a planning grant from HRSA,
4 just a small amount of funding, but it really brought a focus
5 in on data because that was really their intention in giving
6 out the planning grants to get states to look at data. We're
7 not in any worse or better shape, I would say, than most
8 states. Everyone seems to have the same issues with what data
9 is available and the ability to predict.

10 So Delisa always wants me to do Vanna here, so I'm just
11 showing you these are documents that have articles that are
12 dedicated to looking at health workforce that have come out in
13 the last 18 months in Alaska. There is a high interest. We
14 have a great deal of information that has been collected here.
15 The most recent one was one of the *Alaska Economic Trends* that
16 focused on the health care industry. There was also one that
17 focused on social services because that's considered a
18 separate industry, and many of the occupational groups that we
19 have an interest in would fall into that category rather than
20 into the more medically-oriented health care industry.

21 So the graph -- I wanted to just go through a couple of
22 the graphs that came out in this *Trends* article because they
23 are particularly interesting to our conversation, I'd say.
24 The first, we've all talked about many times, is that Alaska's
25 fastest growing industry has been health care for a period of

1 time, and it's predicted to continue, and we've talked about
2 the factors that go into that in the past.

3 The next slide is one that looks at total wages of health
4 care, and it's a fairly interesting picture, to me in
5 particular, because, if you look at the northern part of the
6 state, there is about a \$65 million wage in health care in
7 that area, in the southwest, over \$91 million. There is a
8 \$1.53 billion wage that employees in the health care industry
9 earn. Overall, about 11% of health care workers are non-
10 residents. So that is an indication that much of that wage
11 then gets spent locally and becomes part of our economic base.

12 For professional and technical workers, the harder to
13 recruit people, that is about 15% non-resident. In certain
14 categories, like physicians, it's much higher. Specialty
15 nursing is much higher, but these are sort of overall
16 percentages.

17 MS. CULPEPPER: I just wanted to add to that, Jan, that
18 that payroll, that \$1.5 billion payroll, is larger -- my
19 understanding in reading the labor information -- than the oil
20 patch employees. It's larger than state government employees.
21 You know, it's a large industry, and when you're looking out
22 at economic -- the economic balance of your state, you know, I
23 think you have to decide, do you want to incent employment and
24 do you want to convert out-of-state wages to in-state wages
25 because it is the alternate question to the cost issue to some

1 degree. So it's just a point that one aspect of health care
2 that you, as a Commission, can discuss is the employment
3 aspect.

4 MS. HARRIS: All right. The next slide then looks at
5 where health care jobs are. We've seen varieties of this one.
6 This is a 2010 version. A little over half are in hospitals
7 and nursing homes, and just to point out that, if you have a
8 position in a hospital or nursing home, because they are 24-
9 hour/7 day-a-week facilities, you're going to hire about five
10 people to fill that one position and that really is a driver
11 for the number of workers we have in the health care industry.
12 Next slide.

13 Also looking at preparation for health care workers, that
14 obviously provides a challenge for us, but it also provides a
15 challenge for all of us. The folks who are in health care
16 support occupations are mostly vocationally trained. People
17 in the practitioner and technical occupations and professions,
18 however, most -- about 18% can be vocationally trained. The
19 rest must have a degree of some sort. There is a very large
20 number that show in the associate level. This is the minimum
21 training needed to get a position. All RNs, no matter what,
22 including nurse practitioners, are included in the associate
23 level slice of the pie, and I'm sure that is a big reason that
24 that slice is as large as it is.

25 So in the planning grant, the Department of Labor did

1 have a portion of the grant to really focus in on the health
2 care industry. And so I've put some web links here. I'm not
3 sure if they showed up in the one in your book, but we'll get
4 you this slide separately. They've done quite a bit of work
5 on really expanding and making very readable and very usable
6 the websites they have related to health care. They have an
7 overview page there at the top. I think you may have that one
8 in your book. I'm not sure. And then others that focus in on
9 occupations as well as the industry itself. And then there
10 are a couple of sites for the two *Trends* articles that deal
11 with health care and social assistance.

12 This one is very wordy. I'm going to cover it all, but
13 this was a description that was provided to me about what they
14 were doing with their new Occupations website, and it sort of
15 describes what you'll find there. You can -- you can find an
16 occupation specifically or you can look at -- you can sort
17 that database by wages. So if you're interested in a
18 particular wage, you can look at those and also by employment
19 outlook. Is there going to be a need for this occupation in
20 the future from the DOL projections?

21 When you click on the occupation then, you get a
22 description. You get information about employment, about job
23 openings, wages, labor force indicators, and training and
24 experience requirements, including available education instate
25 or close by. And there is also, if you wanted to get a report

1 on a particular occupation, there is a printer-friendly PDF
2 report that you can click on, on the site.

3 One of the things that they've added this time, they did
4 have a career ladder that sort of showed that occupation in
5 relation to others that might feed into it or might be a step
6 above that a person might want to take. They've also now
7 added a lattice, so you can look at sideways movement. And
8 they really are tracking what particular people in an
9 occupation do. So they're using real information about
10 individuals and where they go in their career paths in order
11 to develop the ladders and lattices. So I think that's a nice
12 feature and something that would be useful for students and
13 parents and others to take a look at.

14 MS. PERDUE: Jan, can I add, too, that there is -- even
15 though we need more information, there is a lot of data. I
16 think that's the point. And you know, the picture of the data
17 is not really squaring up, at least in my mind, although I
18 have to think about it more with the Milliman report that we
19 saw. I mean, I think we all know of extreme cases of
20 shortage, and certainly in areas, there has been improvement
21 in recruiting and in retention, such as perhaps associate
22 level nursing, but in general, I think we still suffer
23 tremendously from a shortage of personnel, particularly what
24 you would call those terminal degree practitioners who are
25 either prescribing or providing the service or making the

1 service happen, whether that's a physician or whether that's a
2 therapist.

3 So you know, I worry that maybe we have downplayed the
4 problem that the data is really actually showing us about our
5 shortages. And then we add to that the issue that, actually,
6 it's probably been a little bit easier to recruit right now
7 because of the economy in the Lower 48, but historically, we
8 know that that changes when the economy picks up in the Lower
9 48. So I would just say that a lot of this data maybe could
10 be used to take another look at the Milliman approach.

11 MS. HARRIS: I think, too, common to many of our
12 occupations and professions is a high percentage of people
13 over the age of 50. So that's a factor that's definitely
14 going to play into this over time, and to me, is always the
15 thing out there that makes me think, even if today we're doing
16 fairly well in some area, that we better be looking to the
17 future and what percentage of that workforce is likely to
18 retire in a short period of time.

19 MS. CULPEPPER: The other thing that goes along with the
20 cost drivers we were talking about earlier today is the
21 percentage of people that are out-of-state workers, travelers
22 that drive the cost up. They traditionally cost 50 to 100%
23 more than a person who is a, you know, regular resident who
24 has a permanent job and that definitely drives the cost of
25 health care up for us in Alaska, and especially Karen said

1 some of the terminal degrees and nursing and docs and
2 psychiatrists and other things that are working on locum
3 tenens contracts.

4 MS. HARRIS: So I just wanted to -- I have, on this
5 slide, quite a lot of words. We've talked about some of this
6 type of data that we have existing, and it comes from many
7 different sources. And so part of this past year has just
8 been identifying what we do have and what the characteristics
9 of the data are.

10 We've also discussed types of data that could be useful
11 that we are either in the process of developing or are
12 planning to develop in the future. We've done several vacancy
13 studies now, usually about two to three years apart. We need
14 to add to those point-in-time studies trend analysis, so that
15 we can really get a picture of how a particular profession or
16 occupation is acting over time. We're looking at university
17 student persistence data as part of our supply discussions,
18 and Department of Labor has recently identified that they can
19 do turnover studies for particular professions, which has been
20 something that's eluded us, to some extent, in the past and
21 has been a type of data that we feel would be very useful.

22 Part of our difficulty within the industry has been that
23 our job titles that we use in the industry and the codes, the
24 national codes that the Department of Labor is required to use
25 don't always match up very well. And so we're working with

1 them to do a cross-walk between their codes and the common
2 titles in use to see if we can develop a better, a more
3 integrated picture of occupations.

4 Department of Health and Social Services has done some
5 licensure studies, is looking at doing additional licensure
6 studies, including looking at locations of practice as part of
7 that. As well, you've heard about the Department's plans to
8 do more community-specific health status data to develop that
9 and that will be very useful for us because, as different
10 communities have different configurations of health and health
11 disparities, the workforce needed will probably differ between
12 communities and that would be a good thing to know for the
13 future. And the Department is also looking at the possible
14 use of discharging claims data.

15 One thing we feel we really need to do is to put
16 together, once we sort of have all of these pieces, a
17 compendium of data that can be updated. We'll probably do it
18 in an online format, the way Department of Labor has chosen
19 to, because that will make it more available and more useful.
20 We've seen an example from Maine where they have about a two-
21 inch, a little bit more bound volume that, to us, is a little
22 less practical, a little less useful. We'd like to do
23 something that's more accessible and can be -- you can sort of
24 move between and sort of see the big picture of a particular
25 occupation. We've made a small start, and we have this in

1 your binder. You saw this in the Health Workforce Plan as
2 well, only in a different -- somewhat different form. But
3 what we've been trying to do is, where we know data about a
4 particular occupation, we sort of collect it all on one piece
5 of paper, so we can look at licensure data, Department of
6 Labor projections, the supply, vacancy study data about that
7 particular occupation all together.

8 Deb and I were talking at the break about our need is
9 really going to be, once we sort of have this -- all of these
10 pieces, is to really to really analyze what we have, how to
11 use each one to try to really get to something that we can
12 hang our hat on and make future plans on.

13 So we're going to switch off of data for now and focus
14 attention on the Action Agenda, itself. You have it in your
15 binder and so we really want to take a look with you at these.
16 And I need to find the page to start at. Page five. We're
17 actually just going to walk through the objectives with you
18 that this Action Agenda includes because these are really the
19 things that we're planning to work on in the next few years as
20 a group. We know that there are lots of other efforts going
21 on. Those will continue. We'll try to track them and make
22 sure there is nothing that we can do as a coalition to further
23 support them, but these are the things that we, as a group,
24 are going to focus on.

25 Karen had gone through the list of 12 focus areas. Six

1 of them are occupations, and six of them are the system and
2 capacity building.

3 The first one was primary care providers. If you look at
4 the bottom of that page and top of the next, we're just going
5 to run through these and give you a sense of our plans. For
6 each of these, you'll notice that someone has -- some entity
7 has been designated as the lead, and we've also attached
8 target dates for the objective to be completed. Each one of
9 these will need further action planning and task
10 identification, so that we can get to the end when we plan to.

11 The first objective under primary care providers -- well
12 just as on overview, the focus for this area for us is on
13 nurse practitioners and also looking at other options for
14 medical education. As Karen mentioned, we're not addressing
15 physician assistant right at the moment. Because of a recent
16 expansion of that program, we want to give it a chance to work
17 and then we'll see what the workforce situation is for that
18 profession.

19 So medical education options assessment will be done,
20 looking at expansion potential for the WWAMI program, but also
21 other medical education options.

22 A feasibility study is going to be done in Fairbanks
23 around a family medical residency both for DOs and for MDs.

24 We have -- we're looking at, and requesting funding for,
25 expanding the nurse practitioner programs. There are two

1 currently at UAA, a family nurse practitioner and a psych
2 mental health nurse practitioner.

3 And then there will be more discussion later in the
4 capacity building section on support-for-service, loan
5 repayment, and employment incentives, and you'll see that one
6 kind of pop up a couple times in here, but we'll address it
7 then.

8 There is a survey going on about physician recruitment
9 and retention, particularly on the retention side, that's a
10 multi-party study that we'll be starting soon. And then we
11 identified that we need to do planning around medical
12 residencies, since they're very critical to being able to keep
13 physicians in the state once they complete their medical
14 education.

15 MS. PERDUE: And that would be done in cooperation with
16 current family residency experts and others, right?

17 MS. HARRIS: Right.

18 MS. PERDUE: So we only have two residencies today, and
19 we're seeking a third. The question would be, what's beyond
20 that?

21 MS. HARRIS: So the next one, direct care workers, I'll
22 turn over to Delisa.

23 MS. CULPEPPER: A few slides back, you noticed that
24 direct care workers make up a big piece of that pie, and
25 often, direct care workers, which is a very broad definition

1 of people that do not have -- could have up to an associate
2 degree, but many times, have just OTJ, on-the-job training, in
3 things. We've been working in the focus area with all of our
4 groups on this one for the last four years fairly diligently
5 trying to develop competencies for direct care workers, trying
6 to define what are the skills and other things across
7 different types of direct care workers, including, you know,
8 personal care attendants, behavioral health aides, different
9 types of direct care workers, and look at their common skills,
10 and we did work with some national consultants to develop a
11 set of what we call core competencies and that was phase one
12 of our project.

13 After that, we developed an assessment tool for
14 supervisors and individuals to be able to look at their
15 strengths and weaknesses across the core competencies, and
16 we're in phase three right now developing training modules to
17 help develop the skills and competencies in the different
18 areas, once people know where they're strengths are. So this
19 helps agencies that have to do their own training for
20 individuals and will be available for free. We'll talk about
21 how we're distributing that a little later on when we talk
22 about the training and other things. So that's been an
23 important one.

24 We're also starting to work on a CNA registered
25 apprenticeship for Pioneer Homes. It's been something we've

1 worked on for a couple years. We're still trying to work out
2 all the particulars of that.

3 We've also worked in different areas to help fund some
4 other CNA programs, one with the Anchorage School District.
5 Career and Technical Assistance is taking off in this area for
6 high schools and other things, whereas we've traditionally
7 thought of Career and Technical Assistance as being, you know,
8 more engineering or other industry-related. Health is really
9 picking up in the last few years, and it looks like we'll be
10 going there. We have a big area -- workgroup in the Coalition
11 working on Career and Technical Assistance. And then.....

12 MS. PERDUE: Let me just say -- you know, these are very
13 shallow dives at some very large projects. And so just to
14 mention on the core competencies, this is nationally ground-
15 breaking work. There is no other state that is looking at a
16 set of competencies. So why do you need those? For a career
17 ladder. You know, that's the basic reason because right now
18 people are moving from job title to job title, whether that's
19 employment-related or payment-related, and the salary
20 schedules are all over the map. So the only way, I think, to
21 impose quality and training and education and advancement is a
22 set of competencies and that's the hope. And so Yale is doing
23 this. The Trust has funded it. It's ground-breaking national
24 work, and hopefully, we can pilot and make it work here.

25 MS. CULPEPPER: It is in the stages of being distributed,

1 and as I said, this is the final year of developing the
2 training modules for it. It's been well-received so far. So
3 hopefully, we'll go farther in that area. Deb, next.

4 Behavioral health clinicians. This is, again, something
5 in the focus area and our partnership with that has been
6 working on for several years. We started out working much of
7 our work with the University. We've expanded out. You see
8 our main objective.

9 The first one is a psychiatric residency that we took to
10 the Legislature last year. We'll be taking it back this year.
11 We still have a shortage of psychiatrists. While we also
12 hope, as you see in our objectives, to increase our supply of
13 psychiatric nurse practitioners and we're working with the
14 University of Alaska to try and do that for the future, we
15 will not get rid of our need for psychiatrists. And this is
16 an area that is heavily subsidized right now through travelers
17 and locum tenens and it's costing our public system for mental
18 health a lot of money, and we think a residency is our best
19 shot after a long study of trying to get a pipeline of
20 psychiatrists that will actually stay here, and it's just not
21 about money. It's about quality. And in the mental health
22 system, having someone who really leads a team, like a
23 psychiatrist does, to provide mental health care and having
24 that stability with the team and with the patients is
25 critical, and we're not getting that right now and it's

1 causing a lot different problems within our public systems,
2 especially.

3 MS. PERDUE: And let me just add, too, that, from the
4 hospitals' point of view, this has been a real important
5 effort. I think hospitals in Alaska have pledged, I want to
6 say, \$3.5 million over the five-year period, you know, in
7 actual money to help jumpstart the residency program. And why
8 psychiatry, among all the shortage areas? Well, one of the
9 reasons, I think, is obviously the need for the service, but
10 the second is it's a doable residency because it's the last
11 two years of a four-year program that the University of
12 Washington has that's quite matched to our needs for rural and
13 community psychiatry. So you know, here's an example of one
14 where we've looked at what's practical, doable, move
15 forwardable, and also some need that we do have. You know, we
16 wish that internal medicine or some of these other areas might
17 be like that, but this is a doable one. And Fairbanks,
18 Juneau, Anchorage, Sitka, many sites are stepping forward and
19 want to use the residency also as a retention tool and a
20 recruitment tool for other psychiatrists.

21 COMMISSIONER LAUFER: Sorry. This is Noah Laufer. Do
22 you have buy-in from the practicing psychiatrists to provide
23 faculty, you know, and educational curriculum?

24 MS. CULPEPPER: Yes. We do. We've been working on this
25 project for three years. We have a psychiatrist that the

1 Trust has been paying to help head the steering committee. We
2 first did a feasibility study, and part of that feasibility
3 study was 1) looking to see, do we have a shortage and then,
4 2) is a residency program something to do. And then the third
5 one we had to look is whether the University of Washington
6 would work with us, what the curriculum was, and whether or
7 not we would have instructors up here, people to oversee the
8 residents. And so that's been a critical element in our
9 initial study of trying to do that. In fact, many of the
10 agencies, especially the public mental health agencies, have
11 known for a while that psychiatrists, when they get to a
12 certain point in their career, don't always want to practice
13 full time. They would like to be practicing and doing
14 teaching. And so this is also an opportunity for a retention
15 tool to retain the experienced psychiatrists and things that
16 we have in our public systems. And so many of them are really
17 wanting to do this.

18 We recently had a chance to talk with a resident whose
19 psychiatry residency was up with NorthStar doing a quick
20 fellowship rotation in child psychiatry, and she was talking
21 about, you know, that's something that would draw her to a
22 place is a future opportunity to maybe do some teaching and
23 work with residents, that it's something they want to do.

24 COMMISSIONER LAUFER: This is very old-fashioned, but
25 it's in the hypocratic oath.

1 MS. CULPEPPER: Yes. So we have lost people to that in
2 the past because there have been no opportunities and so they
3 move on to other states where there are opportunities.

4 MS. PERDUE: Actually, too -- I don't want to extend this
5 too much, but I think it's really an insightful question
6 because let's just take Fairbanks, which is going to be a big
7 site. The existing medical staff there, psychiatry staff,
8 they're burned out. I mean, they're, like, busy. And so what
9 Fairbanks Memorial did was recruit a staff psychiatrist
10 onboard and that person was interested in teaching, so that
11 was a recruitment tool, but without that, I think it would
12 have actually been a negative in the community. And I think
13 that will happen. As the sites come up, there will be a lot
14 of up and down. So you know, developing a residency is a very
15 complicated job, and it's going to change at each site,
16 depending on the staffing.

17 MS. CULPEPPER: The next one we talked about was the
18 psychiatric nurse practitioner, and right now, there is a
19 proposal into the University, and as of Friday, they said you
20 guys are still hoping to do this, and this is a proposal from
21 API that they would fund a position at the University to be a
22 professor, an advanced nurse practitioner who is a psychiatric
23 nurse practitioner, to both be an instructor and then they
24 would practice part time at API, and they would oversee
25 rotations of all the advanced nurse practitioners through API,

1 giving us a little more recruitment and exposure of the nurse
2 practitioners into mental health. Right now, we do have the
3 ability for people to get their degree in psychiatric nurse
4 practitioner, but there isn't a lot of exposure for them. So
5 we don't have a lot of people graduating with that. So we're
6 hoping, through this kind of a mechanism where API wants to --
7 actually, it would be replacing one of their psychiatrist
8 position -- use the advance thing and be able to start the
9 rotations and have access to, at least, a half-time
10 practitioner. So we're working out some risk management
11 issues with the University of someone practicing, but we're
12 hoping that will work for the future because psychiatric nurse
13 practitioners can, as nurse practitioners do in other medical
14 fields, fill a lot of the roles, and up here, they can
15 prescribe, which is important.

16 And the rest of the ones we're working on. Loan
17 repayment, we'll talk about that in the loan repayment one.

18 MS. HARRIS: I'll cover this one pretty quickly. We're
19 looking at both physical therapists and physical therapist
20 assistants in this particular group, and as Karen said, we
21 really have not found a good Alaska solution to this. We are
22 one of three states without a physical therapy program, and I
23 believe only one other state has no PTA programs.

24 So this is -- mainly, the objectives are to assess
25 options for this type of education, including partnerships.

1 Their accrediting body has recently put some barriers in the
2 way of doing partnerships across state lines that we're going
3 to need to work through. We're looking for some funding to
4 get this started, at finding resources to help equip the labs
5 that we'll need for these two programs, and also implementing
6 some version of physical therapy and physical therapy
7 education in the state. I won't dwell on that. There is a
8 lot of work to be done on this one. Next.

9 The nurse area, as we mentioned before, the focus here is
10 mostly on professional development. We focused a lot on
11 getting basic new grads in the past. We're looking now at
12 specialty nursing, at helping nurses who go their education at
13 the Associate's level move to a Bachelor's level, which is a
14 national push, and also looking at nurse educators and
15 increasing the numbers of folks that are involved in that
16 track, which we have available at the Master's level, but has
17 been a fairly small program so far.

18 The objectives are to ensure that there is continued
19 formal industry input into the programs that exist, to pilot a
20 model of an RN to be a (indiscernible - voice lowered)
21 program. We have the program available, but to make it better
22 for the site -- we have 13 sites around the state that we've
23 been graduating associate level nurses in now for a number of
24 years. We need to have a program that will help them, as well
25 as people in Anchorage interested in doing this, move to a

1 Bachelor's level.

2 We're looking at exemplary models for articulating the
3 nursing pathway. We have an objective to have employers
4 encourage education advancement of nurses from RN to BS and
5 above. The hospitals are working together on developing a
6 subspecialty training model that has a lot of promise.

7 MS. PERDUE: I'll just say a little bit about that. By
8 next February, we hope to have a cohort of between eight and
9 12 nurses that will do a perioperative, a curriculum that's
10 based on the Northwest Perioperative. So a very high shortage
11 area in operating room nursing. And so then this one has been
12 adapted from Seattle, where the students can come in every
13 week and do course work on a Friday to a more-intensive
14 situation where Pat's students from Ketchikan can come and do
15 a real intensive. So we're changing the training, but we're
16 also -- it's a total industry-based training program, and if
17 works, then we'll move on to other specialty areas.

18 MS. HARRIS: And then the last one there is working on a
19 plan to develop nurse educators, both to work as faculty, but
20 also as nurse educators in facilities and health care
21 organizations.

22 So the last one of the professions that we're focused in
23 on is pharmacy. We -- the objectives, generally, are to
24 support the current program that we're just getting started
25 and also to explore a new partnership. They include -- the

1 objectives include strengthening the pre-pharmacy curriculum
2 and advising across the system, support our current pharmacy
3 education partnership with Creighton University that's
4 provided five slots for Alaskans in their distance program,
5 and then look into the potential for a more robust instate
6 program partnership. The Creighton Partnership is very
7 limited, and students going through an entirely distance-
8 delivered format need to be, probably, a little more mature
9 and self-directed than all students may tend to be. And so
10 we're looking for something that will give us something more
11 on the ground here.

12 And then we're also -- the Association is in charge of
13 developing a strategy for linking the students that are doing
14 rotations from pharmacy schools in Alaska presently with
15 employment opportunities in Alaska because they often come and
16 go and don't know of possibilities elsewhere in the state that
17 they might return to.

18 MS. CULPEPPER: Before I left the University, Jan and I
19 worked together on, could we have a pharmacy school? And the
20 answer is yes; we could, but we would have the smallest
21 pharmacy school in the country. We are -- are we the only
22 state that does not have a pharmacy school?

23 MS. HARRIS: There are actually two others, but at least
24 one is developing.

25 MS. CULPEPPER: One seemed to be, like, New Hampshire or

1 something where you could drive.

2 MS. HARRIS: Vermont.

3 MS. CULPEPPER: Vermont. So the smallest pharmacy
4 school, I think, that there is right now admits 70 students a
5 year, and it's a four-year program. So you could see that it
6 would be a very difficult thing for us to have our own school.
7 And I think this is the -- obviously, this is the direction
8 that we have to go with all these programs that are direct
9 intra-doctoral programs, where there might be a pipeline that
10 -- let's say UAA and UAF work together or UAS on the science
11 and the pre-req curriculum, which I was learning was not
12 totally standardized between all pharmacy schools, but -- and
13 then track our students, Alaskan students into accredited
14 programs where we have a relationship, so that we're not
15 paying for that infrastructure instate, but we're still
16 creating a relationship like we have with the University of
17 Washington on medical education. And I think that's the
18 direction the University is going beyond the Creighton
19 program; is that right, Jan? Is that generally the idea?

20 MS. HARRIS: I'd say so. One other example is we have
21 another partnership with Creighton on occupational therapy
22 that's a little bit different because, while they distance
23 deliver the academic portion to us, we have the labs and
24 clinicals here in the state. And so we have a presence on the
25 ground. That's kind of what we're looking for for pharmacy,

1 similar to WWAMI. It makes for sort of a better Alaskan
2 version of these things, even though they're partnered with
3 another institution. Deb, you want to.....

4 MS. CULPEPPER: We'll go quickly through the next ones.
5 You've heard us refer to loan repayment and incentive programs
6 several times through our different occupations. We have two
7 different ways we're working on that.

8 One is through our current SHARP program, which has been
9 a partnership between the State, the Trust, and the National
10 Health Services Corps. Right now, we don't have any National
11 Health Services Corps money. We're hoping that there may be
12 some new money coming out next spring, but we do have funding
13 from the State and the Trust that is going forward that is
14 stable, and we'll continue to work on that.

15 We also are working on -- have been working on
16 legislation for the last three years and have a bill currently
17 in the House to work on both loan repayment and other direct
18 incentives, cash incentives, and things for people that don't
19 need loan repayment, but would give people incentives to go
20 and work in underserved areas across a broad range of
21 professions.

22 Training and Professional Development is one of our
23 system capacity issues that we're working on across many of
24 the priority occupations. The Trust Training Cooperatives you
25 see up there is one that we started with our focus area. It's

1 aimed at non-academic training, both through OJT and providing
2 a clearinghouse for continuing education for advanced level
3 professionals in direct service and behavioral health. So
4 we've been working on that for probably four years now or five
5 years. It involves a learning management system, among other
6 things.

7 Now the AHEC, the Area Health Education Center, has also
8 started to use our platform that we've used our learning
9 management system that we developed and are starting an Alaska
10 CACHE, which will be a clearinghouse for training and
11 education for medical, more medical professionals and things,
12 that has just been going live in the last few months and will
13 be completed over the next year. And then Jan, do you want to
14 take the preceptor and mental clinical coaching course? I
15 don't know much about that one.

16 MS. HARRIS: It's a program that the AHEC has begun and
17 is providing information on that helps train preceptors and
18 mentors for students.

19 MS. PERDUE: There is a lot of work going on around
20 background checks because that is a huge delay and a cost. I
21 mean, it sucks up a lot of cost. Employees are having to get
22 multiple background checks. Agencies are having to pay.
23 There is a lack of a system is you want to say about
24 background checks and so the State has taken the lead on a
25 pretty comprehensive initiative to look at background checks,

1 and I think that that could have a huge impact -- maybe Emily
2 could address that at some point -- on getting people on the
3 job, getting them on safely, and also eliminating some big
4 waste from the system. So that's one area, I think, we're
5 going to keep our eye on the ball.

6 We've also -- there is a white paper in your packet on a
7 licensure. Of course, licensure and credentialing are -- you
8 know, they are two different things, but they go hand-in-hand.
9 I think the Division of -- the licensing division and all the
10 boards are very cognitive of the backlogs and those balances,
11 but our members continue to say that this is a huge issue for
12 them, the delay in licensure. So I think there is no simple
13 answer, for sure, across all those boards and professions, but
14 this is an area of a great amount of concern on the behalf of
15 hiring individuals.

16 MS. HARRIS: The next one is to engage and prepare Alaska
17 youth for health careers. There is a lot of activity that's
18 been going on in this area for, actually, many, many years.
19 The AHEC system, as a whole, is focused on this as one of
20 their main mission areas. We've seen, in the last couple of
21 years, the Anchorage School District doing some very concerted
22 work with the Health Career Academy that's mimicked their
23 construction and engineering academies, and it's really taken
24 off, and there are many -- well, 2,000 a year eighth graders
25 get exposed now to health careers as part of their health

1 education course. They've added a great number of courses in
2 the regular high schools in health and that's allowed King
3 Career Academy -- or King Career Center to actually increase
4 the level of the education that they provide there in health.
5 So it's only a couple of years old, and it's quite an
6 interesting and exciting model that we've been participating
7 in. The School District is part of the Coalition.

8 For the next few years, there is one particular project
9 that we're focused on here. There is also work going on by
10 another coalition group in science, technology, engineering,
11 and math for high school level preparation. This particular
12 project is to develop a health program of study that would be
13 available to school districts, provide certain curriculum
14 content during high school that would then articulate into
15 post-secondary education. It's been promoted and is really
16 being moved by the tech prep staff, that their consortium is a
17 large that involves both post-secondary and secondary
18 educators. They've focused in on health as, obviously, we
19 think that's a great idea because it is such an important
20 fast-growing industry, and they're now developing a framework
21 for this articulation and will be piloting the Health Program
22 of Study over the next couple of years. So this is one that
23 we're supporting and engaged in. The Allied Health Alliance
24 of the University is one partner as well as the AHEC, and
25 there will be three school districts involved in the initial

1 pilot, and hopefully, it will be successful and be able to be
2 spread across the state.

3 MS. CULPEPPER: I'll just say a quick word about our work
4 with the Department of Labor in recruitment and with youth.
5 The Department of Labor is, you know, responsible for hosting
6 the state jobs website, and we have not, in many of our
7 careers, taken a large advantage of that, and we've worked,
8 over the last year, to really help engage the Department of
9 Labor with some of our providers, especially in the direct
10 service workers and other things, and will be working with
11 them in both their job fairs and their career fairs in the
12 area for youth. The Department of Labor does go out in the
13 spring and do career fairs to high school students and other
14 things, and we want to work with them for their people to have
15 the information about health careers and behavioral health and
16 direct service careers to let students know that there is a
17 really broad breadth of careers from on-the-job training to
18 advanced level in urban and rural full time jobs that they can
19 do and try and engage their interest and plug them into the
20 system somewhere.

21 So we also have been doing, for the last four years, a
22 media campaign through our focus area to try and engage
23 interest in other, not just youth, but people that may be in
24 second careers, people coming out of the military and other
25 things to engage in some of our direct service careers and

1 behavioral health careers. So we'll continue to fund that and
2 try to look for new sources of workers for our industries.

3 Karen?

4 MS. PERDUE: You know, recruiting can be kind of a
5 cutthroat thing, you know, especially if you put a lot of
6 money into it and then your recruit goes to some other entity,
7 but I think, more and more, there has been a realization that
8 this infrastructure for recruitment can't be -- you know, it's
9 wasteful not to do some pooling and some teaming up. So
10 especially for the rural hospitals, there has been quite a bit
11 of thinking around that and some good work going on on
12 physician recruitment, and I think there's more groundwork to
13 be done. I think the Tribal Health Consortium has done some
14 pooled recruiting as well. I'm not saying this is without
15 challenge. It is, but you know, just a common website that's
16 a portal that shows how great Alaska is, and I know our poor
17 ASHNHA website gets a lot of hits, and I'm thinking to myself,
18 oh my gosh, we've got to put better pictures up and not just
19 of our board members. We have to have some mountains up
20 there. I think we all have to be mindful and look at our web
21 hits and see who is hitting our web, and we'd be surprised
22 that a good percentage of those are from out of state, looking
23 at the job market. So anyway, that's what that's about. So
24 let's go to the conclusion slides. I think we did the.....

25 MS. HARRIS: Yeah (affirmative). We've talked about the

1 data one.

2 MS. PERDUE: We've done data. So what do we need from
3 you? I think you're probably thinking, oh my gosh, who are
4 these people and all the work they're going to do, this big
5 long list? You know, we're not, obviously, going to be doing
6 the work ourselves. There are entities, institutional
7 partners that are doing a lot of this work, but what we've
8 done is try to group these things up so that they can be
9 tracked, cheerleaded, supported, you name whatever the
10 appropriate thing is.

11 So what support would we request from you for this next
12 year? These seem to be the things that are queued up that
13 might get some action this year and that we could use some
14 support for, and I think we've gone over them. So we don't
15 need to really do that in more detail, but those were the
16 things that are takeaways for us, beyond the broad idea of
17 supporting this idea of keeping sort of a list, a tally of how
18 we're doing and reporting out to you, which is quite helpful,
19 I think. These are some specific things.

20 CHAIR HURLBURT: Thank you. Questions and comments?
21 Pat, please?

22 COMMISSIONER BRANCO: And I'm not going to make any
23 comment about how I look. I have a statement and a question.
24 The first one, the statement. I didn't hear -- I'm wildly
25 enthusiastic about youth programs because I look longer term

1 than just my immediate vacancies. These are how we're going
2 to build our infrastructure in the state. The HOCSA, the
3 Health Occupation Student Associations, I've just begun
4 interacting with these kids, and I couldn't be more blown away
5 with their enthusiasm, their professionalism, and I think
6 that's another area that we want to continue to endorse,
7 especially out in our rural communities. They get the
8 opportunity to job shadow in the local hospitals and get a
9 taste of health care early on and then they compete, both
10 statewide and nationally, and I think they're making good
11 showings. And so they're a group that we ought to be proud of
12 and start to fertilize a bit and help them grow into the next
13 phases as well.

14 My question is on nursing programs. It's an enormous
15 challenge to find faculty because, usually, the senior nurses
16 are already making a substantial wage, and not to say that
17 faculty are less paid than industry staff, it's pretty hard to
18 go backwards in your career. And so how do you -- do you have
19 thoughts on incenting nurses or encouraging them, or you know,
20 bold as it may be, collecting retired nurses who may become
21 faculty members?

22 MS. HARRIS: Yeah (affirmative). Actually, that's really
23 one objection is to try to identify what we can do to
24 encourage working nurses, but I think also folks who are
25 retired or nearing retirement to get involved. Mostly, they

1 need to be Master's prepared, at least, and that's why the
2 Nurse Educator Track was developed to start with, to try to
3 start growing our own, and I think that's going to be an
4 ongoing push. But looking at how to encourage nurses to
5 participate in being instructors is something we'll be looking
6 at this coming couple years.

7 COMMISSIONER ENNIS: Thank you. Well, I'd like to
8 applaud the work of the Coalition. It is certainly
9 comprehensive and meaningful and directly related to our needs
10 and communities, and most importantly, I'd like to thank you
11 for including the direct service workforce in your efforts.
12 You know, it has been a neglected entity in the health care
13 profession, and with the growing need for a larger direct care
14 workforce, we need all the help we can get to recruit and
15 maintain and develop qualified workers.

16 The area of core competencies is very important because
17 our direct service workforce all needs a similar foundation
18 related to the philosophy and the key skills and abilities
19 they need to develop, and it's very challenging for community-
20 based services to be able to offer this kind of comprehensive
21 training.

22 We have been affected by cost containment over the last
23 five to six years with frozen rates, and many of the
24 strategies to continue operations in the face of that is to
25 eliminate many of our mid-level, axillary positions and that

1 includes trainers for our workforce. So that core competency
2 training will address that in a very important way.

3 The other fact that Karen did mention is the turnover in
4 the direct service workforce that we're all challenged with.
5 In many agencies, that turnover is 50% for the entire agency,
6 but in certain positions, for example, direct service workers
7 in group homes, assisted living homes, the turnover is 100% or
8 more and that's a turnover rate around our country, not just
9 in Alaska, but unfortunately, we are replicating that here.
10 And when you think of constantly trying to bring in those
11 individuals who are not experienced, perhaps have a GED, have
12 perhaps never even been exposed to a person with a disability
13 or a disabling condition, you can only imagine the sense of
14 fear and lack of confidence that families have when faced with
15 these new workers and the legal exposure, the liabilities that
16 employers have in putting folks out to work with really very
17 little front-loading in the area of skills and abilities and
18 attitude and understanding of the outcomes of the field. So
19 this is really critical, and the fact it will be available to
20 agencies who offer long-term community-based services around
21 our state is going to be wonderful. So thank you very much
22 for that.

23 Just real quickly, you asked me to comment on background
24 checks, and again, this is another high cost, another
25 disincentive to recruitment and keeping our workforce wholly

1 staffed. My agency has about 300 direct care workers, so
2 we're constantly refilling those positions, \$75 a background
3 check, the paperwork involved. The potential employee may
4 have just had a background check two months ago at another
5 agency. We can't access that.

6 The bigger problem is, you know, the wait time that
7 occasionally occurs and that could be, in the best of the
8 situations, three days for a provisional. That's not a final
9 background check, but a provisional means they can go to work,
10 but often, it can be two to three weeks because of a backlog
11 at the Background Check Unit.

12 So what happens is an employee that -- or a potential
13 employee is hoping to start to work right away, and we have to
14 say no; we can't hire you, and they can go down the street to
15 another employer, not necessarily direct care, not a
16 community-based service agency, and get hired right away. So
17 there, we lose a potential employee and that's been the
18 biggest negative impact. So I would, again, applaud a more
19 coordinated background check system that addresses some of
20 these concerns.

21 And then lastly, I would like to speak to the value of
22 the AHEC program and the youth health care development, the
23 education that's related to that, and I understand Fairbanks
24 may soon have a Health Care Youth Corps to volunteer in the
25 non-profit agencies in our community, and again not only does

1 this give them education about the type of work that's out
2 there, but that hands-on experience in different agencies
3 around our community, I believe, will encourage them not just
4 to have a better understanding of what that service is all
5 about, but a connectivity to future employment in our
6 community. So I think that will happen around the state as
7 well. So thank you very much.

8 COMMISSIONER FRIEDRICHS: Well, thank you. I'd like to
9 echo Emily's compliments to you all. Thinking back to your
10 last presentation, it's obvious there has been a lot of work,
11 and seeing the two efforts come together is very heartening
12 because there is so much work to be done. It's good not to
13 duplicate efforts trying to accomplish the same thing.

14 I would also echo the comments about background checks.
15 We've had a little experience with background checks in the
16 military, and they are certainly not easy to do. It is
17 impressive how difficult it is to get through the Alaska
18 system right now for folks who may have a top secret
19 clearance, but then have to wait to get a background check in
20 Alaska. So I commend you for highlighting that.

21 I have a whole page of questions, and I'll send some of
22 these to you offline, but the one thing that I did not hear
23 you mention was public-private partnerships. I've heard some
24 comments that TriWest Healthcare has offered a matching grant
25 opportunity for the state of Alaska, a multi-million dollar

1 opportunity to support recruiting clinicians. Are you all
2 aware of that, and your thoughts on that?

3 MS. PERDUE: I was aware of it last year, but I've lost
4 track of -- I think some of the local hospitals began the
5 dialogue, but I will check back on that.

6 COMMISSIONER FRIEDRICHS: And I mention it because,
7 certainly, that's been an area in other underserved, or
8 relatively underserved, states in which a public-private
9 partnership, like that, has been very successful. Hawaii is a
10 great example where TriWest, in particular, as I recall,
11 partnered with the state, and with matching funds, was able to
12 open rural clinics. Clearly, we have that need, and as you
13 look at workforce opportunities, I would commend that to you
14 as another opportunity to consider reviewing and offering to
15 the State. It would certainly be unfortunate if we missed
16 this opportunity here in Alaska.

17 You had mentioned \$1.5 billion spent on the healthcare
18 workforce. Do you have the number or the amount of money out
19 of that \$1.5 billion that goes to those imported workers? I'm
20 thinking towards our report. That's a powerful statement to
21 say that, of the \$1.5 billion, this much actually then is
22 spent out of state, and I didn't see it, quickly reviewing the
23 background information, but if it's possible.....

24 MS. HARRIS: We can get that fairly easily from Labor.

25 COMMISSIONER FRIEDRICHS: And again, I'm just trying to

1 think of how to build the most compelling problem statement
2 that -- you know, to say that 11% of the workers are from out
3 of state is one thing. To say that \$400,000 is being spent in
4 Washington instead of in Alaska may be a little bit more
5 compelling as we craft this.

6 In your issue paper number four on professional
7 licensing, you have three recommendations, which are fairly
8 high-level recommendations. When I look at your "support
9 requested for" slide there, are you asking that the Health
10 Care Commission endorse these recommendations or are there
11 more specific areas when you -- you mentioned some kind of
12 generic things are. Can you help me understand how we can
13 help you with this?

14 MS. PERDUE: The licensing issue is -- it was in more
15 detail. I think what ASHNHA's board is endorse this document,
16 which is a very much high-level -- working in these various
17 areas. So that would be an option for the Commission is to
18 endorse either the effort or the document, but certainly not
19 every word in the -- you know, all the white papers. I think
20 that would be fairly tedious to do.

21 COMMISSIONER FRIEDRICHS: And I -- thank you. I agree
22 with you. We had this discussion on the teleconference a
23 couple weeks ago about trying to grapple with that. I guess
24 my concern then is, if someone is going through reading a
25 report that says that we endorse somebody else's report that

1 has 38 recommendations and Organization B reports there is 40
2 recommendations, it may also be difficult for them to parse
3 out the key action items for this year. If you were going to
4 go back to your "support requested for" slide and help us with
5 what you see would be the this-year areas of focus, I believe
6 what I took away from your discussion, one of them was the
7 psychiatric residency. We got very close last year and didn't
8 quite get that football over the goal line there. Is that a
9 correct understanding, from your comments, that that is a
10 focus area for the near-term?

11 MS. PERDUE: That's very much a focus area for us. The
12 loan repayment is another. Actually, all of those things on
13 that slide there are, you know, and I know the Commission
14 struggles with the issue of you're not an appropriator or a
15 financial bank. These are all things that need some help.
16 Without some help, they probably won't go as far as they need
17 to go. So that's why we put them on the slide for you.

18 COMMISSIONER FRIEDRICHS: Thank you. And then you had
19 mentioned the family practice residency in Fairbanks; is that
20 an approved -- or did I understand correctly that there is
21 going to be a family practice residency in Fairbanks or is
22 that an idea?

23 MS. PERDUE: There is a feasibility study that Fairbanks
24 Memorial is undertaking in cooperation with the University of
25 Washington and the D.O. school in Yakima to see if there could

1 be a dually-accredited residency. It's a feasibility study.

2 COMMISSIONER FRIEDRICHS: And then.....

3 MS. PERDUE: But I believe they would be eligible. I
4 think the important thing is they would be eligible as a rural
5 site for an additional residency in family practice. So that
6 is a new piece of information that will be confirmed in the
7 feasibility study, but has been a barrier for Anchorage to be
8 able to expand beyond -- the graduate medical education rules
9 have really inhibited that, so that might be a breakthrough.

10 COMMISSIONER FRIEDRICHS: That's a huge breakthrough.
11 That's fantastic news there, to get around some of the CMS
12 constraints. Two last points, if I may.

13 One, as Emily said also, kudos on the core competency
14 discussion. We've spent the 15 years in the military
15 developing those, and it has helped tremendously to have
16 clearly defined core competencies to help our nurses and our
17 other direct care members progress. If you're looking for
18 examples, I suspect we'd be willing to share what we've put
19 together with you all.

20 And then the last point. You mentioned residencies and
21 GME planning. Is there sort of an overarching plan that
22 you've laid out, prioritized residencies that you see needed
23 for the state and then a way ahead to get there?

24 MS. HARRIS: I think there are a number that have been
25 discussed, but I don't think we have a plan yet and that's

1 really what we're aiming for.

2 COMMISSIONER FRIEDRICHS: Thank you.

3 CHAIR HURLBURT: Pat?

4 COMMISSIONER BRANCO: I wanted to pick up on one of
5 Paul's comments and that's the private-public partnership
6 possibilities, and Jan will remember when we started the
7 nursing program and I look at things on here, like the
8 Physical Therapy Careers Program. I guess it was seven or
9 eight years ago in which we identified the need in the state
10 to have our own nursing program. We used to import Weber
11 State, from Utah, nurses into the state, put them through some
12 of the rural sites, and grow and develop, and eventually,
13 hopefully, hire them. We knew that was an inefficient
14 process. So in partnership with the University of Alaska, we
15 asked the industry to step forward, and each hospital was
16 asked to -- each small hospital was asked to throw in \$50,000
17 as seed money over a three-year period to get this launched,
18 and I think the response was overwhelming. Well, the fact
19 that we have a really solid nursing program through that
20 public-private partnership is one solution that we ought to
21 look at for these critical needs again because I know, for
22 one, I'm all in for physical therapy, ultrasonography, the
23 things that we can do here. The partnership will actually
24 produce results.

25 MS. HARRIS: I should mention we actually are almost at

1 the point of launching an ultrasound program, just so everyone
2 -- take heart. Take heart.

3 COMMISSIONER BRANCO: By the way, I'll pay \$15,000 for
4 an.....

5 MS. HARRIS: Probably don't have -- the hospitals donated
6 between \$5 and \$6 million towards the nursing program in order
7 to get it doubled and spread out across the state.

8 CHAIR HURLBURT: I'd like to make a comment and kind of
9 turn it into a question then. I think you all have done a lot
10 of thoughtful work, and certainly from a lot of the things
11 that the Commission has heard and is in existence -- for
12 example, the second item there, loan repayment, I think those
13 of us anyway who were here, when we were looking at that, were
14 convinced that's the quickest and most cost-efficient way of
15 getting folks that you need into place quickly. I think the
16 focus on the physician area where, more than anything else,
17 it's probably been on primary care, on family medicine
18 specifically, both with what's been done here already with the
19 WWAMI program, U-Dub, with the family medicine residency,
20 probably the odds of getting an aspiring physician into family
21 medicine are better here than very many places in the country,
22 and I think that's the need and that's commendable.

23 But I've got my book with me, my *Tracking Medicine*, and
24 the quote on the back from Alaska's friend and sometime
25 Alaskan Don Berwick that anybody who is interested in health

1 services research should read the book. I think that there is
2 ample documentation there that the industry that we're in --
3 that basically, by and large for the most part, if you build
4 it, they will come. And so if we -- you know, you have done,
5 like I say, a thoughtful and a careful job of looking at
6 demand around the state and tabulating that and prioritizing
7 that and looking at potential ways to meet that demand, but
8 there is good documentation in Wennberg's work and others
9 that, as we expand capacity in our business, the business
10 grows, and we're already at 18% of GDP nationally and 20% in
11 Alaska. I would say that maybe the fast food business would
12 be the same thing, but when the McDonald's in downtown Juneau
13 closed last year, I think maybe we're maybe ahead of the fast
14 food business. And I think that a reasonable response to
15 turning this into a question is well, that's not our task or
16 that's not our job or that's not our assignment, and yet, you
17 wouldn't be doing this without the deep commitment to this
18 whole business of meeting the needs of people where they hurt.
19 There are certainly shortages nationwide.

20 Last week's *Newsweek* magazine had a little short thing on
21 where the jobs are, and it said occupational therapy about
22 8.7% vacancies per position. Interestingly in terms of our
23 needs for mental health, one of the lowest vacancy rates was
24 of family and marriage counselors at 0.2% nationally, so
25 suggesting it's not a very good thing to go into right now at

1 that Master's level type program. But you know, how do you
2 see your role in identifying what you've done so nicely and so
3 well the demand that we have in Alaska, and then maybe in the
4 more macroscopic picture when you say well, that's above my
5 pay grade, but of putting it together with the economic
6 realities that we face? And I'm sure that you've discussed
7 this because we can't avoid facing it.

8 MS. PERDUE: It's probably above all our pay grade in
9 some way, but to the extent it's not above our pay grade,
10 health care is a people business. You know, you cannot
11 deliver health care without labor, qualified labor, and you
12 know, my impression having moved from the University side to
13 the provider is the requirements on quality, which relate to
14 cost, are about how you've got the right people to deliver
15 that care. I mean, you cannot get good outcomes on quality
16 without trained people. You might be able to actually, if you
17 have just an excellent rigid system, but probably, you're
18 going to be a lot farther along if you have trained people.
19 So when you've got turnover and you've got temporary workers,
20 you know, you've got 50% perioperative nurses that are
21 travelers in your OR and you're being judged on your clinical
22 outcomes, I mean, it doesn't take a rocket scientist to see
23 that you could improve that. So I think it's really about
24 quality and then it's about cost.

25 And then on the issue of supply-for-service, that is

1 really something where I just, as an Alaskan, struggle because
2 I served on the Fairbanks Memorial board through the
3 development of our cardiology unit. We previously had no
4 cardiology services in Fairbanks. Now there are three
5 cardiologists, and those cardiologists employ around 50
6 people. Every one of those people lives in Fairbanks, have
7 bought a house, send their kids to school. Is that good or
8 bad? It cost the system money, but it provided a lot of
9 service and a lot of jobs. So I mean, I think you, as a
10 Commission, have to really come down on this question, maybe
11 not pro or con, but you do have to wrestle with it because we
12 still do not have basic services in many places in our state,
13 and to get those, we need people.

14 MS. CULPEPPER: I think that the things we've been
15 working on the last four or five years with direct service and
16 behavioral health are more around quality, also the cost of
17 doing business for recruitment and retention. As Emily said,
18 it drives the cost up when there is such turnover and not an
19 ability because most of our -- our systems in direct care and
20 behavioral health are very heavily funded by public funds and
21 other things that there isn't money for training and other
22 things, and it's just a vicious circle. The less training,
23 the less time people stay in jobs, there is not supervisory
24 training and other things.

25 So we've been concentrating more on those things for

1 quality and to reduce the cost of recruitment and retention.
2 If we retain more, we're going to have to recruit a lot less.
3 And for some of our direct workers, it's not about locum
4 tenens. It's just about quality or not having the people, and
5 there has been an increase in the need for direct care and
6 that we can't mitigate with the aging of our population in
7 Alaska. We will continue to have that kind of demand. So it
8 isn't always a lot more workers. It's having the right
9 workers with some kind of quality assurance. I mean, most of
10 us don't want to have ourselves or our relatives taking care
11 of people who have absolutely no training and no standards.
12 And behavioral health care is just a necessity in places, and
13 a lot of our work that we've been doing is getting the right
14 people in the right place. We don't have mental health
15 services available with a stable workforce in some of the
16 rural areas and so that's been more what we've been working on
17 and controlling cost.

18 Again for them, one of the biggest things we've seen in
19 our vacancy study and other things, as we've developed in the
20 last ten years a human service degree and the behavioral
21 health aide system, that those are the big vacancies. You
22 know, they're great employment opportunities for people in
23 rural Alaska and they're very training-intensive for some of
24 them, but they also have a lot of turnover and that costs a
25 lot to the system.

1 CHAIR HURLBURT: Thank you. Any other comments or
2 questions? Jeff, please?

3 COMMISSIONER DAVIS: Thank you, Dr. Hurlburt, and just
4 compliments to you all on your work in pulling this together.
5 It's quite impressive. Dr. Hurlburt, I think your question is
6 a sage one, and Delisa, your answer was a good one as well. I
7 think, for -- I look at these numbers maybe from a little
8 different point of view. I look at the employment numbers,
9 and I'm thinking, you know, that's a lot of dollars and I know
10 how those dollars get covered, by increasing health insurance
11 premiums. And so this is a circular cycle that we've got
12 going here. And so everything you said, Delisa, is true about
13 quality. If we can connect the dots though to say, you know,
14 you don't have to hire a traveler who costs twice as much;
15 therefore, you know, you will see an increase in utilization
16 perhaps. Or I guess, with a traveler, that's not a good
17 example, but with -- so you take some of those dollars and
18 spend them on education, retention, and recruitment. That's a
19 great investment, and it puts dollars here instead of
20 someplace else. So connect the dots there.

21 I think there's also though some other dots that can be
22 connected, the ones that you just said around, you know,
23 quality improvement. Therefore, better outcomes, better
24 retention. Therefore, lower cost overall, et cetera. If we
25 can -- to the extent that, in your work, you can connect those

1 dots, it makes it easier for us all to say yeah (affirmative);
2 this makes not only, you know, social sense, but it makes
3 financial sense as well. So I would encourage you to follow
4 that thread and see what you can do to help us help support
5 you. Thank you. Great work.

6 CHAIR HURLBURT: Anybody else? Thank you all.

7 COMMISSIONER ERICKSON: We have ten more minutes, and I
8 am struggling with something, and Jeff was actually just
9 getting at it. You got at it a little bit. And so maybe I
10 can just think out loud for a few minutes, and if there is any
11 response, because, at some point, I'm going to be writing this
12 up relatively soon and we'll talking this afternoon about what
13 we want to do with this, as a Commission, as well. And I
14 really struggle a lot and have pushed even, with not much
15 success, the economist who we work with to understand the
16 tradeoff between the contribution to local labor markets of
17 health care and impact on the economy and the benefit to the
18 economy as opposed to the cost of the economy, and I think,
19 Jeff, that's really what you were getting at.

20 And thinking about the presentation by the two
21 Commissioners last week, their concerns about the fact that
22 oil revenues, 90% of state General Fund revenues, and even if
23 oil costs stay as high as they are, we still are going to be
24 facing the crossing point in the next decade that state
25 revenues are going to be less than state expenses.

1 ICER put a report very recently about the two main
2 drivers of our economy being oil revenues -- Alaska's economy
3 and growth in Alaska's economy -- oil revenues and federal
4 spending. So we're looking at a 5% decline a year in oil
5 production right now, and it's just the high prices that are
6 continuing to keep us floating, although those could go at any
7 time, and federal spending. And with the work on the federal
8 debt burden and reducing that, if we're looking at those two
9 main drivers of our economy going down, and to Jeff's point,
10 the money that's paying the salaries of the health care
11 workers, it's wonderful to have those health care jobs and
12 those folks in our community and we need them to provide the
13 care, but it's the community that's paying their salaries.
14 It's not new money coming into the economy through some sort
15 of production mechanism.

16 So anyway, what I've pushed the economists on and they
17 don't answer my question is, what's the right point where we
18 have sufficient health care workforce to support the delivery
19 of care, good quality care, and it's not negatively our
20 economy? And I'm just -- not the organization that Allen
21 represents, but another organization in Alaska that represents
22 small businesses, recently, I heard their leader -- I won't
23 say who it was, but it seemed like such a huge disconnect to
24 me.

25 He was talking about how wonderful it was they had some

1 new businesses coming into their community, health care
2 businesses from outside coming in and how wonderful this was.
3 It's going to buoy up our economy in our community to have
4 these new health care businesses here, and in the next breath
5 -- and not making the connection at all -- what he said then
6 was the biggest challenge to small business in our community
7 is the high and growing costs of health care insurance
8 premiums and we're having businesses drop coverage for their
9 employees, and not making the connection that, as we grow the
10 overall pot for health care spending in a community, we're
11 driving up the amount of money that the individual businesses,
12 individual Alaskans, public programs are spending.

13 So what I really struggle with is -- and I know there's
14 no answer and that's why I nag Jan every time I see her about
15 the data piece -- can we, at some point, have sufficient
16 information and analytical capacity from the data -- and maybe
17 we won't; maybe we just need to keep struggling through this
18 together -- to have a better sense of what the return on
19 investment will be? We need improved quality. We have
20 factors related to the workforce that are making our health
21 care costs higher. Maybe we need to just focus on what we
22 know those workforce factors are, at least the Commission,
23 focus on what we know those workforce factors are that are
24 making health care costs higher in our recommendations. I
25 don't know the answer to those questions. That's why I push

1 Jan all the time on the data piece. Do we have sufficient
2 data? And then, do we have sufficient capacity to turn that
3 data into useful information? And are we ever going to be
4 able to answer the question, for increased investment in the
5 workforce, are we actually getting a positive ROI? And one
6 final thought, because we look at what -- the Commission is
7 focused on what can we do or identify that's new and
8 innovative, and we look at Alaska's tribal health system as a
9 model. It's used as a model in other countries and other
10 states now. More and more other states are coming to study
11 our tribal health system because of some of the innovative
12 things they've been able to do, and where they didn't have the
13 resources to just put more money -- pour more money into
14 meeting a need in Bush Alaska, they were very innovative in
15 coming up with new worker types, new types of workforce,
16 community health aides, the dental health therapists,
17 behavioral health aides. Is there some way we can focus our
18 energy on being innovative and finding some innovative
19 solutions? So I guess those two questions, after that very
20 long comment. Paul, Noah, and Dave?

21 COMMISSIONER FRIEDRICHS: So wow, that's -- let's see.
22 You covered world hunger, global warming, and world peace. So
23 the data is out there to answer part of that question, and
24 Ward probably can answer this more authoritatively than I can,
25 but the biggest contribution that we've made in this country

1 over the last now 111-112 years has been clean water and basic
2 public health. And so you know, from the standpoint of not
3 novel, but the biggest contribution to improving health and
4 life expectancy has been very basic interventions that we've
5 made, and this goes back to why we've retained that in our
6 charter here that there are still some areas that don't have
7 access to that, and I would offer that we want to continue to
8 highlight that.

9 The second one that's been absolutely fascinating for me
10 to study is I've spent more time looking at China and
11 comparing it to the evolution of health care system. Their
12 life expectancy went from 28 years for an adult Chinese in the
13 1930s to around 60 to 65 years in the 1960s, in spite of all
14 of the different political issues you may have. The single
15 biggest intervention they made was to have something like our
16 community health aide in every community. It was a very basic
17 level intervention that focused on public health and on
18 perinatal care. Those were the two primary areas in which
19 they changed dramatically the life expectancy and the overall
20 health of their community. Interestingly, as they got rid of
21 those, they are now seeing their longevity curve bending. And
22 so one could argue that all of our discussions, like, you
23 know, we need more MRI techs, or you know, high-end right
24 kidney ultrasonographer or whatever, are going to have a very
25 -- and I say that as someone who uses right kidney

1 ultrasonographers as a urologist -- marginal impact on what
2 you're discussing.

3 Absolutely fascinating study and one that I was going to
4 ask you offline, Karen, but I'll throw it out there. So the
5 Fairbanks' experiment -- and I call it that for the purpose of
6 this discussion -- with cardiology was a fascinating one
7 because you all, as I understand it, had traveling
8 cardiologists coming up. There was a known demand. Then you
9 hired cardiologists to come work there full time, and the
10 utilization dramatically exceeded any projection of what you
11 all thought the need was in that community and that's been the
12 same experience that we've had in many communities around the
13 United States. If you build it, it will get used because
14 people want to have access to health care.

15 What I've not seen is the follow-on done. Have the
16 number of people who've died of cardiac-related conditions
17 decreased in Fairbanks? And I've asked that question a couple
18 of times, not of you. So I'm not trying to throw you under
19 the bus, but that's where, potentially, we could close that
20 loop to say that, indeed, there are some interventions that
21 really do make a difference. You increase the number of
22 taxpaying, working age Alaskans because of the fact that you
23 have cardiology available in their community, and they don't
24 have a three-hour airplane ride before they can get a cath
25 done. And I offer that as an observation, really, to get back

1 to what you're doing, that yes; the data is out there, but
2 it's not all been cross-tabulated.

3 I'll end by saying that the discussion we had a year ago
4 about the New Mexico public display of data is how we could
5 move forward with that because, if we took all of the data
6 which we currently have and put it out there, some bright
7 young graduate student would be sitting there right now
8 crunching this data saying look at the outcome's impact of the
9 experiment with cardiology in Fairbanks. That's going to be,
10 I think, the answer to many of those questions is to make the
11 data more readily available.

12 COMMISSIONER LAUFER: Just to, I guess, reiterate it, I
13 think I'm saying the same thing. I'm thinking of the Minister
14 of Public Happiness in Bhutan. You know, they're measuring it
15 and that's actually -- it sounds crazy, but it's actually
16 where we're at because, you know, the employers, including me,
17 are saying we can't pay anymore. Jeff's saying I can't sell
18 insurance because there is no margin because everything costs
19 so much. The doctors really -- you know, we're talking now,
20 which is a good thing. I'll talk to you about that, Jeff.

21 But basically, the question for us is, well, what do you
22 want to buy? You know, what are you looking for? The
23 patients, most of us right now, want everything. So I can
24 tell you, even if it only extends my life by two weeks, if the
25 oncologist says I should be on the \$150,000 chemotherapy and

1 somebody else is paying, I would like that.

2 And the real question is, what do we want out of this?
3 You know, where, as a society, what percentage of GDP are we
4 willing to spend on being, you know, healthy or happy, and how
5 do you measure health? That's why, remember, I asked, what do
6 you mean by health? What do mean by mortality? Because it
7 actually matters. I mean, you can be alive and have a
8 terrible quality of life, you know. Obviously, this line of
9 thinking goes on and on, but you know, we have to decide what
10 percentage of our GDP are we going to spend in this one loop
11 around a non-productive service industry to have a high
12 quality of life.

13 And to go one step beyond that, we live in a world now
14 where capital and talent can go anywhere and live anywhere it
15 wants, and part of being competitive, you know, is to be a
16 place where people who have capital and talent want to live
17 and raise their children and that is a valid economic reason
18 to invest in a good health care structure. But you know, what
19 do you want? What do you want from medical care? What do you
20 want from your doctor? Do you want to have basic things, like
21 not die in misery, poverty, and loneliness at the end of your
22 life? I mean, that's what Medicare was about initially,
23 right? We have to decide that. And the other term for this
24 is rationing.

25 COMMISSIONER MORGAN: Oh, goody. I actually sort of said

1 something like this at the primary care conference two weeks
2 ago, and I think Commissioner Streur was talking, and
3 honestly, I had gone to -- it was either a Commonwealth North
4 meeting or a Chamber meeting. Noah was there and heard this
5 twice, I think. And it was a discussion on employment
6 opportunities and economic development, and it was health care
7 growing. The U-Med is probably going to spend a couple of
8 hundred million dollars on buildings, if you throw in the
9 building you just opened, a couple of long-term care
10 expansions, and I'm not kidding. Three days later, I'm at
11 another meeting, and half the people were the same people, and
12 the whole conference was about we can't afford health care.
13 And I asked -- the Commissioner just walked in and I asked him
14 the question, and I was standing by Dr. Eby and a couple other
15 people. You know, (indiscernible - voice lowered) Law,
16 marginal utility. What -- how can you balance this? And he
17 was a little quicker off the mark. He said, well, we just
18 have to balance the books, which means you can take it anyway
19 you want. We all know that value mathematically in health
20 care is equal to the quality divided by the price.

21 I think we are getting very close to getting to where we
22 can get the math of this, or at least, set the parameters of
23 what the math is. it comes down to whether the Commission is,
24 basically, going to bite the bullet here, if not this year,
25 next year and give some recommendations. Some of them are

1 going to be liked. Some of them are going to be really not
2 liked, which is bad language, I guess, and it depends on whose
3 ox is going to get gored. We know it's not sustainable. We
4 know we're groping around to find where we're going to get to,
5 but fundamentally, you've got \$7.5 billion health care stuff
6 going on, and when you look at it, \$2.5 billion of it is,
7 basically, dollars coming from outside the state, the federal
8 government, VA, Medicare, tribal. Watching the budget
9 confrontation on the national level, that's going to stop --
10 one way or another, if we -- from the military on down, we're
11 going to have Draconian cuts, if Congress can't figure
12 something out to do about it. And if they do figure out
13 something about it, we're going to have Draconian cuts to deal
14 with it. I think we're between a hard place and a rock, but
15 fundamentally, I think we're going down the right track to
16 pull together enough numbers and enough concepts to do this,
17 but I think, as the Commissioner would say, we have to have
18 the right people, and I would caveat it with the right trained
19 people to do the things they're supposed to do with quality at
20 the right place and the right time, and then I'll add, at the
21 right cost, and that's the trifecta in this. If we get
22 anywhere -- even if we just sort of get close, it will have a
23 profound effect on the system and what the system is costing
24 all of us. And all I can say is it's going to be a whole lot
25 of fun in the next year getting to there, but I do think we

1 can do it. I think, though those other economists wouldn't
2 answer you, it's probably because they really want a contract,
3 you know what I mean? But as a guy that is an economist, I
4 think, generally, and from a macro level, we can get there.
5 The issue is those macro changes that happen, what will be the
6 micro effects down to the firm or the practice? And I think
7 that's why we're kind of creeping along here, in that we
8 really don't want unintended consequences to do something
9 really bad, which makes you go a little slower, but slower
10 doesn't mean we don't go, and we're going to have to. So the
11 good news is yeah (affirmative), some. The bad news is yeah
12 (affirmative), some because sometimes there is going to be
13 some individuals, parts of the industry that really aren't
14 going to like it, whatever comes out of this, but hey, what
15 the heck? I'm close to retirement, right?

16 CHAIR HURLBURT: Thank you. I think we've probably -- I
17 know there are one or two other comments, but we probably
18 should break for lunch because we're kind of hardwired for our
19 public comments at 12:30. We've got just 20 minutes. As
20 usual then, if I could ask if those who are attending and not
21 on the Commission, if you could maybe hold off on getting
22 lunch and let the Commissioners get their lunch, and then we
23 will start right at 12:30. Jan and Delisa.....

24 MS. CULPEPPER: One last thing. I just wanted to tell
25 you that we forgot to tell you that, you know, we gave you the

1 short version. This is the long version. It will be on our
2 website, 118 pages. I know you can't wait to see it.

3 CHAIR HURLBURT: Thank you all very much.

4 12:10:36

5 (Off record)

6 (On record)

7 12:34:54

8 CHAIR HURLBURT: If we could come back together again,
9 thanks for everybody getting your food promptly. We're still
10 wrestling a little for the folks online. What we'll do is
11 have the public comments from the folks in the room first. We
12 have about five or six folks here for that. And then we'll go
13 to the folks online. I think, at this point, you can hear us.
14 We're still working to make sure that we can hear you. We
15 have an hour for this. So I think we'll have plenty of time,
16 but I think, for those who have public comments, if you could
17 maybe limit to no more than four or five minutes, we should be
18 okay for that. If we have more folks online, we might have to
19 cut that back a little bit, but that should work. So the
20 first one on the list here that we have -- and if you have a
21 public comment, if you could come up to the microphone at the
22 table here.

23 The first one is Fred Brown, who is here of the Health
24 Care Cost Management Corporation of Alaska. And if you could
25 just press the little silver bar there, that will turn it on

1 for you.

2 MR. BROWN: Thank you. As mentioned, my name is Fred
3 Brown. I'm the Executive Director of the organization Health
4 Care Cost Management Corporation of Alaska. The name pretty
5 well describes what we try to do. We're comprised of about 35
6 public and private self-insured employers and trust funds
7 which provide health benefits for employees across the region.
8 Approximately 60,000 covered lives are here in Alaska and then
9 we have an additional 55,000 or so in the Pacific Northwest.
10 We fit squarely into the definition of commercial purchasers
11 of health care, as discussed this morning.

12 I want to congratulate all of you for being willing to
13 take on the difficult tasks. It was interesting listening to
14 Deb and others discuss the tension that exists between
15 bringing new money into the economy, at the same time, making
16 our region and state attractive to new businesses.

17 Our organization is active in the Alaska State Chamber of
18 Commerce, and I think the State Chamber understands the
19 tension that exists between the two factors that Deb and
20 others described earlier, and yet, the Chamber has observed,
21 many times, that Alaska is, of all the states in the United
22 States, one of the least attractive for bringing new business,
23 and the cost of health care is a key component of that lack of
24 standing in this 50-state poll.

25 This week, the State Chamber is going to have a work

1 session here in Anchorage on the topic of how to get a better
2 handle on the high cost of worker's compensation costs,
3 medical and otherwise. And the purpose of my testimony today,
4 primarily, is just to observe that that Milliman report that
5 you all have been listening to preliminarily over the last two
6 sessions could be very helpful in the Chamber's efforts,
7 looking at worker's compensation costs going forward. So
8 anyway, I would simply encourage that, to the extent that the
9 Milliman report can be finalized and released as quickly as
10 possible, we would sincerely appreciate it. Thank you.

11 CHAIR HURLBURT: Thank you very much, Mr. Brown. Do you
12 have any questions from the Commission? Yes, Wes?

13 COMMISSIONER KELLER: Thank you, Fred. We met earlier.
14 How do we compare with other states in our workman's comp
15 costs?

16 MR. BROWN: On a couple of points, you know, overall as
17 described a few moments ago, we're very unattractive for
18 attracting business, and as the Chamber has circulated
19 probably to some of you, one of the key components for the
20 rationale for that low standing is our high worker's
21 compensation costs.

22 Now you know, personally, I've been a Worker's
23 Compensation Hearing Officer for 25 years, until I took this
24 job here two-and-a-half years ago. When I first came into the
25 system back in the 1980s, medical costs were about 52% of the

1 entire cost of the worker's compensation system. Now it's
2 75%. So it's becoming an ever-increasing component that needs
3 attention and that's the purpose of the State Chamber's
4 meeting this week.

5 COMMISSIONER LAUFER: That shift from 52 to 75, that is
6 unique to Alaska?

7 MR. BROWN: The shift has occurred elsewhere in the
8 country, but that dramatic of a shift is unique to Alaska.

9 COMMISSIONER KELLER: Just a quick follow up on that.
10 The reason I asked the question is I was reading here recently
11 in a book called *Woes* by Laffer, L-a-f-f-e-r, an economist.
12 In that, they rate the states, and I'm pretty sure he put
13 Alaska number one in our costs.

14 MR. BROWN: Yeah (affirmative). Over the last six years,
15 Alaska has either been number one or number two every year,
16 and in fact, I can tell you that Alaska was never number one
17 every year, except for last year when Montana rose to the
18 number one spot. Alaska dropped to number two. Montana made
19 some very dramatic changes in their worker's compensation
20 benefit structure and specifically focused on medical costs as
21 one of the components, and the result, Alaska is number one
22 again.

23 CHAIR HURLBURT: Thank you very much.

24 MR. BROWN: Thank you.

25 CHAIR HURLBURT: The next we have is Dr. Chelsea

1 Haponski, who is representing the Alaska Chiropractic Society.

2 DR. HAPONSKI: Hello. Yes. I am Dr. Chelsea Haponski,
3 and I just wanted to thank you all for allowing us to come and
4 speak today. I have noticed, throughout looking at the
5 different documents and listening in on the Commission's
6 meetings, that there is a recurring theme of provider
7 shortages across the country and especially here in the state
8 of Alaska. It appears, to me, that the Commission hasn't
9 explored the chiropractic profession as an avenue for helping
10 fill the provider shortages.

11 Currently, the American Chiropractic Association has
12 passed resolutions to help states across the country utilize
13 chiropractors to help fill the workforce gap. Our Alaska
14 Chiropractic Society is working closely with our national
15 organizations to help our state here in Alaska.

16 We would like to help in filling this gap because,
17 currently, there are a lot of chiropractors in remote villages
18 in areas that currently are areas that we are seeing that
19 provider shortage, as far as primary care physicians, and
20 again, those chiropractors are already there. Why not use
21 providers that are already in those areas to kind of fill some
22 of that void?

23 Again, we, as the chiropractors in the state of Alaska,
24 would like to help, and if you guys are interested in setting
25 up some sort of a meeting or discussion with you or a task

1 force committee, again, we would like to help in anyway that
2 we can.

3 In addition, in a lot of the areas around Alaska,
4 chiropractors in general tend to be committed to the
5 committees that they're in. They typically have a standalone
6 practice, and they're there from the time they start to the
7 time they retired. So again, you're not going to have that
8 influx of providers coming in and out and leaving on a regular
9 basis. They tend to stay in that area. So that was
10 (indiscernible - voice trailed off).

11 CHAIR HURLBURT: Pat?

12 COMMISSIONER BRANCO: Thank you for that. In our
13 community in Ketchikan, our chiropractors have lab and x-ray
14 privileges at the hospital, but that's only a small portion.
15 I've seen a white paper from the national association that
16 talked about the expanded role of chiropractors in medicine,
17 chiropractic medicine, and it talked about expanded privileges
18 in hospitals. Can you say anything -- you mentioned the gap.
19 In what way can chiropractors help fill the -- and I presume
20 this is in the primary care realm?

21 DR. HAPONSKI: Yeah (affirmative).

22 COMMISSIONER BRANCO: Can you expand on that?

23 DR. HAPONSKI: Yes, to some degree. One, chiropractors
24 in our education, we are educated and licensed in being able
25 to diagnose, treat, manage, and co-manage patients' conditions

1 and are referring to other care providers. So in a lot of
2 ways as far as being able to do lab work and blood work and
3 screenings for diabetes and things like that and then send
4 them on the route that they need to go, as far as which
5 providers they need to be seeing following that,
6 chiropractors, in general, are starting to work more
7 cooperatively with other health care practitioners in really
8 trying to have patient-centered care that we're trying to get
9 those patients to the right avenue, based on what they are
10 finding. And chiropractors tend to see a patient more
11 frequently than maybe even a primary care provider. So a lot
12 of times, we tend to pick up on things that the patient
13 wouldn't go into a clinic for or whatever, just because we
14 happen to see them on a more regular basis. So I don't know
15 if that answers your question or not.

16 COMMISSIONER BRANCO: And so just to summarize for
17 myself, so not as a substitute for primary care, but a real
18 augmentation of whole patient care?

19 DR. HAPONSKI: That, and they could be used as primary
20 care, as far as -- one of the big things that we currently
21 cannot do is prescribing medications. So obviously, that is
22 one thing that kind of inhibits us, but again, we're not
23 opposed to, if there is something that we aren't currently
24 trained to do, being able to add in some sort of a training on
25 that or educational background to help, again, fill that void

1 because, again, we're already in those positions. We're
2 already in those locations, you know. Let's see what we can
3 do to help.

4 CHAIR HURLBURT: Allen and Wes and Paul?

5 COMMISSIONER HIPPLER: Ms. Haponski, other than
6 prescribing medications, what would you be asking for? Are
7 there licenses that chiropractors would require or is there
8 any other power that they need?

9 DR. HAPONSKI: You know, I'm not sure on that. I would
10 probably have to get back to you on that. Like I said, I'm,
11 by no means, the expert on a lot of this, but I do know that
12 chiropractors -- currently, we can take x-rays and do take x-
13 rays, do a lot of lab work, and it's -- we have a pretty broad
14 scope as far as what we can do as far as practicing. The big
15 one is that we currently are not doing any sort of major
16 surgeries, prescribing medication, that sort of thing. So as
17 far as education, you know, I'm not sure on what the need is
18 in a lot of these communities, but again, the chiropractic
19 profession is open to helping out in whatever way we can.

20 COMMISSIONER HIPPLER: A quick follow-up. So if I get
21 strep throat, you want me to be able to call my chiropractor
22 to get treated for that?

23 DR. HAPONSKI: Again being a resource for patients in
24 those areas where there may not be a primary provider, that
25 yeah (affirmative); they'd be able to go to a chiropractor and

1 say hey, what could I do? And again if we need to be taking
2 some pharmacology classes to be able to prescribe something
3 for somebody, you know, or getting an additional degree of
4 some sort, again, I'm not sure what all would be entailed as
5 far as correlating the boards and the requirements as far as
6 that goes.

7 CHAIR HURLBURT: Wes, please?

8 COMMISSIONER KELLER: Thank you, and thank you for taking
9 -- coming out and talking and testifying the way you have.

10 Being a carpenter and a homebuilder and a contractor and
11 a pilot, you know, I don't really fit on this Commission, you
12 know. (Indiscernible - voice lowered.) So the words primary
13 care provider, I had to define that. And I remember being in
14 Point Lay, Alaska and the -- what was it, Val? The village
15 nurse, right? That was the primary care provider. And what
16 I'm saying is that the primary care provider is the one that
17 has the expertise to look at me and give me a direction to go,
18 if I'm the one sick, right? And the Commission has been
19 looking at the medical home model, and I think your offer to
20 use chiropractors in the portal into -- you know, as an entry
21 point into the health care system of Alaska is an excellent,
22 and I appreciate your suggestion.

23 CHAIR HURLBURT: Paul?

24 COMMISSIONER FRIEDRICH: Thank you, Mr. Chair, and thank
25 you, ma'am, for joining us today. As you think through the

1 opportunity to partner with the other folks in the community,
2 one of the thoughts that I would offer for your consideration
3 is, as we look at a pie that's not going to get any larger,
4 the reimbursement rate for chiropractors, based on the data
5 that Milliman has shared with us, is considerably higher than
6 it is for some other primary care specialties and so what we
7 may wind up doing were we to expand the scope of care for
8 chiropractors is to actually increase the cost of health care
9 delivery. And so one of the questions I would pose to you is,
10 how we would balance that tradeoff of higher costs? How would
11 we justify that as we move forward with a very limited amount
12 of resources to spend on health care?

13 The second point that I'd offer for your consideration,
14 as you think about how you could partner with us, is the scope
15 of care issue that my colleague, Mr. Hippler, raised there.
16 With the very specific standard of care or scope of care
17 delineations that we have for primary care providers and for
18 nurse practitioners and others today, there is a pretty clear
19 understanding of what training is required before someone can
20 do a certain task in the health care industry, and I think it
21 would be helpful, at least for me -- I won't speak for the
22 whole Commission -- to understand what changes need to be made
23 in the scope of care for chiropractors, if we were to endorse
24 what you're recommending. Certainly if we were to move
25 forward with that, I think we would all want to ensure that

1 we're offering the State both, at least as good quality, and
2 ideally, good value in a new initiative, like this. So I'd
3 offer those two points for your consideration.

4 DR. HAPONSKI: Thank you.

5 CHAIR HURLBURT: Any other questions? Thank you very
6 much for coming. Appreciate your sharing with us, Dr.
7 Haponski. Next, I have Karen Perdue. Are you going to shift
8 hats, Karen?

9 MS. PERDUE: Thank you. I'm not going to address
10 workforce again. I'm Karen Perdue, CEO and President of State
11 Hospital Nursing Home Association. I wanted to give a couple
12 of comments on the dashboard that you have in your packet that
13 we've been working on. It looks like this. And then I wanted
14 to make a couple of comments on the conversations, policy
15 recommendations you're going to have this afternoon because it
16 looks like that's the best time to do that; is that right?

17 COMMISSIONER ERICKSON: I just wanted to let folks know
18 that the dashboard Karen is referring to is behind tab three
19 in your notebook.

20 MS. PERDUE: So under Pat's guidance, we formed a group
21 of CFOs from our organization and various organizations to sit
22 down and digest the reports, the financial reports that you're
23 producing and also just try to give us some guidance, and we
24 started to develop this dashboard, which is in the process of
25 improvement, and we would take any improvements that you would

1 have or comments that you would have, but I wanted you to look
2 at number eight on the first page, which is kind of a summary
3 of how many hospitals we have and what they are.

4 So we have 28 hospitals in Alaska, and almost 80% of them
5 are either critical access hospitals, tribal hospitals, sole
6 community hospitals, or military or veterans' hospitals. We
7 really don't have -- of course, we have the large non -- the
8 MSA hospitals, but the bulk of the number of hospitals, 80% of
9 them, are in some kind of special reimbursement designation.

10 Now you know, critical access hospitals are set up by
11 Congress and they pay 101% of costs under Medicare, and
12 Medicaid pays 100% of costs, not more or less, 100%. They
13 only want to pay cost. So it doesn't really surprise me that
14 we're coming out 136% or 137% higher -- or 37% higher because
15 we have so many of our facilities that are under these special
16 designations. Understand that the report does not include
17 some of this information, such as military or tribal, but you
18 can still see that there is a preponderance. And then I'd ask
19 you to think about the fact that most of the non-military
20 tribal hospitals are run by municipalities. They either own
21 the infrastructure or they own and operate the actual
22 facility.

23 So when you're doing this report, this cost driver
24 report, I hope there is some element in there of the community
25 nature of our hospitals and the special and unique blend. And

1 so we tried then, in the dashboard, to show the ratio of
2 critical access hospitals that we have versus the comparison
3 states, so we have that information for you as well.

4 The occupancy rate information that we got from the AHA
5 does not seem to square up with what we saw in the Milliman
6 study, and I don't know why, and you know, we could be wrong,
7 but it doesn't seem to square up AHA, which is a really pretty
8 good data source.

9 And then the other thing is the uncompensated care. You
10 know, hospitals are open 24/7, and so when people walk in and
11 they need service, they have to get it. So it would be good
12 to recognize that, and perhaps the study is going to do that.
13 I don't know.

14 And then on the second page, on page -- the chart 16, you
15 know, really the costs of labor in most of the things that
16 we're looking at quite a bit higher in Alaska than it is in
17 the comparison states. And so I wasn't able to really see on
18 the chart all the detail there and didn't know how it was
19 weighted, you know, in terms of the professions, but I ask you
20 to look at that, too, because I think the cost of labor in
21 Alaska is driving the cost of health care to some degree, and
22 it doesn't make, to me, just anecdotally, that they wouldn't
23 be seeing much difference in the cost of labor.

24 So those are just some very basic comments, but the
25 dashboard is, again, meant to, you know, sort of be an easy

1 reference. We'll probably incorporate some of the things that
2 we find from the Milliman study in the dashboard and have it
3 available perhaps in January for our session.

4 The final thing is I ask you to look at number 12, the
5 box number 12. We started to look at this question of
6 ruralness in terms of where are the patients coming from. You
7 heard a little bit about that from Milliman in terms of the
8 length of stay, but they took four diagnosis codes and tried
9 to look at the length of travel. So they took the zip codes,
10 of course, of where the patients were from and tried to look
11 at how far they traveled to get treatment for those services.
12 So I'm not sure what kind of message it's showing us compared
13 to the national average, but 40% of our patients being served
14 in Alaska hospitals are coming 60 miles or more for their
15 service, which could explain a length of stay issue. So you
16 know, we have a high degree of people coming into hospitals
17 that are traveling what, in the Lower 48, would be considered
18 to be a long distance. In the Lower 48, 60 miles is -- you
19 are in a frontier category. You're out in the boonies. Here,
20 it's not that.

21 So those are some comments on what we've been doing in
22 ASHNHA to try to look at demographics of ruralness.

23 CHAIR HURLBURT: Val and then Wes?

24 COMMISSIONER DAVIDSON: I just wanted to compliment
25 ASHNHA for this data, and I guess my observation is that 100%

1 of the data, basing decisions on 100% participation and
2 utilization of the facilities is always better than basing
3 decisions on 64% of the information available, and it appears
4 that it cost us a lot less. So I just want to compliment your
5 great work. This is really great information. Thank you.

6 COMMISSIONER KELLER: Yeah (affirmative). Thanks. This
7 is great. Do the urban hospitals sometimes transfer patients
8 back to the non-MSA hospitals to get the Medicare down, so
9 that might also show some -- be some reason why there is less
10 efficiency shown in the non-MSA hospitals? I was wondering
11 that when they were making their Milliman -- I see Pat's got
12 an opinion. That's great.

13 COMMISSIONER BRANCO: No. Patients are returned to their
14 communities at the end of their critical phase or their acute
15 phase and often will come back to either long-term care or a
16 skilled nursing facility for rehab until they're finally going
17 home, but they don't come back to complete their care.

18 CHAIR HURLBURT: I thought -- on your comment on length
19 of stay, when we had the chance to first hear it, with just
20 the challenges and the logistics of care, where a 10%
21 difference, essentially, was just slightly under half-a-day
22 difference with the difference in having folks go away and not
23 having care there, I thought that was fairly impressive to be
24 that close to the national norms on that. I think your
25 comment was right on.

1 MS. PERDUE: So in general, I would say, you know without
2 reserving for review of the Milliman third phase report, you
3 know, I worry that the ruralness of the state is not really
4 reflected in the charts that we saw. That might not be the
5 whole report, but it would be good, for the person who is
6 never going to look at anything other than this report because
7 they are too busy or they're doing something else or they're
8 not a health policy wonk, to infuse some of that into the
9 document because we are very unique in that way. So that's
10 kind of my summary comment in that regard.

11 The other thing I wanted to mention is that I think that
12 you could see that the transparency of reporting for
13 hospitals, at least some of the hospitals, is providing data
14 and that is an important thing. I've heard the Commission
15 talk a lot about that. And in the long-term future, other
16 provider groups will be coming forward, through Medicare or
17 other measures, and reporting.

18 How we use that information is really important to incent
19 reporting. So where you have the hospital situation now in
20 the Milliman study where hospital care is 40% of the spend and
21 now you're subtracting a good percentage of the hospitals
22 because you can't get the data, you're down to looking at the
23 MSA hospitals, four hospitals, basically, in terms of some
24 summary information. So again when you go back and look at
25 the narrative, think about that because, if the headline is,

1 you know, hospitals have high operating margins, but in fact,
2 it's really down to one or two hospitals or it doesn't reflect
3 the complexity of the hospital situation, you know, that's
4 something that you have to worry about. And I'm very mindful
5 of the comments that my friend, Keith Campbell, and others
6 have said is that nobody wants their ox gored. I understand
7 that, but hospitals are reporting, and we will continue to
8 report and improve our reporting. So we're just wanting to
9 understand how the numbers are displayed.

10 So then my final comment on that is that we have been
11 working on the data issue, the discharge data issue. You
12 talked with us -- we talked with you about that last meeting.
13 We have moved forward on participating in some of the national
14 databases that we planned on doing. The board has approved
15 doing that so we're providing more data to the national
16 agencies through the HCUP program, and our board will be
17 looking at dedicating some resources, taking some of the
18 resources that the state provides us, along with some of our
19 own money, and trying to beef up our data engagement with our
20 hospitals to try to get more hospitals to report and to try to
21 start working on quality.

22 So to the extent that your recommendations reflect that
23 more should be done, understand that we want to do this in
24 partnership so that, if there is a need to get all hospitals
25 to participate, we feel we have a responsibility to be

1 involved in that. And we actually feel that hospitals are
2 perhaps more receptive to working through ASHNHA than
3 necessarily only just the state. So I just say that the
4 recommendation is quite clear and simple, and it says you
5 recommend that the State of Alaska encourage full
6 participation in the hospital discharge database by Alaska
7 hospitals, but perhaps you want to add some sentiments there
8 about working in partnership with the industry.

9 And then regarding the All Claims Database for Alaska, I
10 know there have been presentations about that. That is an
11 ambitious goal, and my recommendation on that would be, at
12 least as far as I know right at this moment, that you look at
13 a feasibility study. Well, what does that mean? What -- how
14 does that -- what kind of work does that entail, because
15 that's a fairly large undertaking? So perhaps a feasibility
16 study would be the first step in that direction.

17 CHAIR HURLBURT: Thank you, Karen, very much. I think we
18 have three more here and then those on the phone. Just a
19 quick comment, Paul?

20 COMMISSIONER FRIEDRICHS: (Indiscernible - away from mic)

21 CHAIR HURLBURT: We're 35 minutes into an hour, and we've
22 only had three folks go so far. So go ahead, if it's quick.

23 COMMISSIONER FRIEDRICHS: Karen, thanks very much. On
24 the data that you've provided here, how would you recommend
25 that we reconcile the data that you're showing for all of the

1 hospitals in Alaska, with the Milliman data? And then I think
2 you hit the nail on the head. The Milliman data is a focused
3 data set. That report is going to become available, and the
4 one comparison is that, for all hospitals across Alaska, there
5 are clearly some constraints, but that still doesn't address
6 the difference in margins between the MSA versus the non-MSA
7 hospitals. So I guess I didn't understand that in your
8 comments there. How are you recommending that we address that
9 or view that?

10 MS. PERDUE: Well you know, we haven't seen the
11 narrative, but the narrative is important and also the
12 conclusions are important, how they're written. So that
13 information, hopefully, can be shared, and we can comment on
14 it. You know, I just -- if cost of living in Alaska is, at
15 least, 25% by the federal government recognized as higher --
16 or perhaps higher and hospital costs are 36% higher, then is
17 it -- you know, one statement said hospital costs are very
18 high. I mean, is that right or is it high as reflected by the
19 cost of living and other things?

20 So what the report says is important, and I'm just saying
21 that our industry would like to comment on the report and
22 provide additional data for them to look at.

23 CHAIR HURLBURT: Thanks. I wonder, do we know how many
24 folks online may have any questions? Is there anybody online
25 that has questions that would like to testify rather?

1 DR. KOHLER (ph): This is Dr. Kohler; no questions.

2 CHAIR HURLBURT: Thank you. Anybody else? Okay.

3 Shelley Hughes from Alaska Primary Care Association?

4 MS. HUGHES: I'll keep it short. I have no notes. And
5 actually I'm going to testify in regard to something I brought
6 up about this time last year, and it is to challenge you, as a
7 Commission, to really be bold and to be leaders in what you
8 put forward in your recommendations. I know, later in the
9 day, you're going to be looking at -- and through the rest of
10 this fall -- all year, you've been hearing information, and
11 you have excellent discussions at the conclusion of hearings
12 of all the data and the presentations and the expertise that
13 you bring to the table and the innovative ideas, some of the
14 out-of-box thinking that I've heard as I sat through these
15 meetings through the year, and I just encourage you to be bold
16 and be specific. And I said that last year, and I'm going to
17 say it again because the reference was -- the discussion was
18 that one of the -- Senator Davis made the recommendation that
19 this body wasn't to get very specific. And I think, when I
20 look at the statute of your establishment, I don't see that in
21 it, and as someone who works in government affairs and spends
22 a lot of time in the offices of policymakers, a lot of them
23 don't know you exist. I'll take the report in. They don't
24 know anything about it, and they leaf through it, and it seems
25 somewhat general and generic. And so I really encourage you

1 to get as specific as you can based on the information that
2 you have. You don't want to do something, unless you know and
3 it's been reviewed thoroughly and you feel confident in those
4 recommendations. And I do know that your Executive Director
5 and your Chair are state employees and they do work for the
6 Administration, and you all were appointed by the
7 Administration, but the Governor appointed you because of your
8 expertise, and he wants you to give direction.

9 So I really encourage you, if you're not giving
10 specifics, for one thing, you're not going to get the
11 attention of the policymakers, and yet another year, the
12 report, the recommendations will collect dust. And so I just
13 encourage you to really think. Go back to the statute, if you
14 need to. Go back to the mission. We've got families. We've
15 got businesses. This state is really relying on this because,
16 I mean, you all hear about the problem every time you get
17 together. It is important. I'm hearing of grandparents
18 wondering whether they can stay in this state. You know, are
19 we going to be able to keep our families together? Are we
20 going to be able to bring in business? Health care is
21 important. It's very pivotal. And so you do have that weight
22 on your shoulders.

23 And so I just encourage you to be as specific as you feel
24 like you can in the recommendations, and I hope and look
25 forward to reading the report and seeing that you were able

1 to, in your language -- as an example, the loan repayment and
2 incentive remark has been referred to in some of the reports,
3 but it shouldn't just be one of the ways that some states have
4 seen have been helpful. Your language should be establish a
5 loan repayment and incentive program. It should be very
6 specific, like that. So those are the kind of things -- of
7 course, that's one of the things I've been working on. So of
8 course, I'd like to see that in there, but there are other
9 things in there as well in regard to other issues. So that is
10 my challenge to you today as you start this intense process
11 the next couple months of preparing that report for January.

12 CHAIR HURLBURT: Any questions for Shelley? Paul?

13 COMMISSIONER FRIEDRICHS: I can't resist asking our
14 senior and esteemed mentor Representative Keller for his
15 thoughts on that. From the standpoint of the Legislature, are
16 we more effective if we are more specific or more generic?

17 COMMISSIONER KELLER: Oh, I tend to concur that, you
18 know, the specificity is what is wonderful because -- you
19 know, and being clear, you know, that's the other side of it,
20 not -- it's very easy to read it when you're not in the field
21 and miss things. We were talking a bit earlier about primary
22 care. That's a perfect example. That's something I had to
23 learn, you know, and you take it as second nature because it's
24 in your -- I remember I think it was -- I'm pretty sure it was
25 Commissioner Streur who politely explained to me what tertiary

1 care was in the Committee one time. It was humbling, but what
2 I'm saying is yes, specificity; I concur and also clarity and
3 a little bit of time with the background. Yeah (affirmative).
4 Thanks.

5 COMMISSIONER HIPPLER: Mr. Chairman, there is a slide
6 that we haven't gotten to yet. It's on page five, slide
7 number nine. It says, because it is beyond their charge --
8 this is for the Meeting Discussion Guide today. It says,
9 "because it is beyond their charge, the Commission" -- and one
10 of the things is, "does not take positions on specific federal
11 or state appropriation decisions and legislation." Would
12 that, for example, include the loan repayment program?

13 CHAIR HURLBURT: My interpretation would be no, that
14 that's directed more toward specific federal programs, but
15 that it's appropriately within our purview, as Shelley
16 suggests, that, if we feel that the loan repayment program is
17 a good thing, we can support it. Now we can't support a
18 specific piece of legislation, which, you know, Shelley would
19 prefer that we, I think that's not appropriate for us to do,
20 but conceptually, I think, if we feel that this is a good
21 thing to meet the needs of Alaska, it's appropriate for us
22 state that. Any other questions? Shelley, thank you very
23 much.

24 MS. HUGHES: You're welcome.

25 CHAIR HURLBURT: Next, Nancy Sanders from Board of

1 Nursing? Okay. Then the last one I have on the list is Donna
2 Stevens from Hospice.

3 MS. STEVENS: Thank you for having me here with you again
4 today. I'm Donna Stevens with Hospice of Anchorage. I just
5 want to remind you that Hospice of Anchorage has been here 30
6 years. We do not charge for services, and I think that's
7 important when you're -- we're totally supported by community
8 donations. We do have a grant from the State of Alaska for
9 senior in-home care and helping to keep people in their homes.

10 But what I wanted to bring to your attention was the
11 impact that dying has, both on quality of health care and
12 costs of health care. And there was an article in the *Journal*
13 *of American Medical Association* this month, October 5th I
14 wanted to bring to your attention, and it talks about the
15 regional variation associated between advanced directives and
16 end of life Medicare expenditures. And it's one of the first
17 times that we're -- or I have seen, anyways, this kind of data
18 being pulled together, and it's beyond the ability of Hospice
19 of Anchorage to look at what does this mean for Alaska, how
20 could we extrapolate this data to Alaska, and I'm hoping that
21 that's something, as you're moving forward and looking at end
22 of life care and it's impact on health care costs, that this
23 might be a direction that we could go to find out whether this
24 really makes a difference in Alaska.

25 We, as Hospice people, board, and staff, feel that end of

1 life care needs to start a lot earlier, that we need to be
2 comfortable to talk about end of life, avoiding that crisis in
3 the hospital where we no longer can tell if we're living with
4 or dying from an illness, and we're not talking about it early
5 enough to avoid the crisis of people dying they don't want to
6 be, trauma for family and survivors, and it's -- we've just
7 got to move it back, and we believe that that's possible.

8 I wondered, if any of you had an opportunity to see that
9 KAKM Special, "Consider the Conversation," that was in August?
10 It was an excellent one. We do have availability of a DVD, if
11 any of you would like to watch it. And just -- 100% of us are
12 dying, but we don't -- you know, the state plan for seniors
13 just came out, and it has one line that hospice and end of
14 life care, we should advocate for in every community. You
15 know, we just need such a broader view, and I think that's
16 really where this Commission can have large impact. Thank you
17 very much.

18 CHAIR HURLBURT: Any questions for Donna?

19 COMMISSIONER LAUFER: I'd just like to say thank you.

20 MS. STEVENS: You're welcome.

21 CHAIR HURLBURT: Yeah (affirmative), and I'd echo that.
22 Thank you for what you do.

23 MS. STEVENS: You're welcome. It's an honor to do it.

24 CHAIR HURLBURT: Thank you.

25 COMMISSIONER ERICKSON: And I wanted to mention to the

1 Commission members, too, that I do have a copy of the article
2 that Donna just referenced, and maybe we can get copies for
3 all of you, since one of the things that we'll talk about
4 tomorrow is identifying our items for our agenda for study and
5 recommendations for next calendar year and on our parking lot
6 list of issues that have come up over the past couple years
7 now, end of life care is on that list.

8 CHAIR HURLBURT: Is there anybody online who would like
9 to comment or testify? Anybody else in the room that didn't
10 sign up that wished you did? Okay. Thank you all very much.
11 We'll move into our second session related to long-term care
12 and the challenges that it presents to us, the opportunities.

13 Duane Mayes is going to be chairing that for us, and with
14 him will be Thea Agnew Bembem to talk about long-term care.

15 COMMISSIONER ERICKSON: We actually are a few minutes
16 early. Why don't we take five minutes, just to get their --
17 make sure we have the PowerPoint set up and the speakers in
18 the room because we're ahead of schedule. So they're not
19 probably quite ready.

20 CHAIR HURLBURT: Okay.

21 1:17:51

22 (Off record)

23 (On record)

24 1:30:45

25 CHAIR HURLBURT: If we could come back together for our

1 next session. As I mentioned before, this is our second panel
2 to kind of follow-up to the initial presentation that we had
3 earlier on long-term care, and Duane Mayes, the Director of
4 Senior & Disability Services, and Thea Agnew Bemben have come
5 to join us today. And what we've done on the earlier
6 presentations is say, if there is a burning need for
7 clarification or a question during your presentation, folks
8 should feel free to interrupt, but generally, we'll try to let
9 you go through it and then open it up to questions and
10 comments and discussion from the members of the Commission.
11 So thank you all for being here, and I'll turn it over to you,
12 Duane.

13 MR. MAYES: Well, thank you. So again, my name is Duane
14 Mayes, and I'm the Director for the Division of Senior &
15 Disability Services, and I'll have Thea introduce herself and
16 her role with this Committee.

17 MS. AGNEW BEMBEN: I'm Thea Agnew Bemben. I'm one of the
18 principals with Agnew Beck, and we are a contractor to the
19 Mental Health Trust, and we provide lots of different kinds of
20 technical assistance, but we were assigned to this project to
21 assist the Division with the beginning phases of this Long-
22 Term Care Steering Committee. So we've been assisting Duane
23 and the Division with the work that the Committee has done in
24 the last four months or so.

25 MR. MAYES: Six months.

1 MS. AGNEW BEMBEN: Six months?

2 MR. MAYES: Approximately, yeah (affirmative).

3 MS. AGNEW BEMBEN: Wow, six months. It's already gone
4 by.

5 MR. MAYES: Time flies. So who is managing the
6 PowerPoint? Is that going to be you?

7 So to start with, I wanted to just kind of lay the
8 foundation, the purpose of this presentation is to explain to
9 all of you the state of long-term care in Alaska and recommend
10 a planning process and guiding questions for the future of
11 long-term care in Alaska. So next slide.

12 So our agenda today will be to do an overview of the
13 planning process to date. You heard Thea mention six months
14 and so I'll talk about that.

15 Background information that we've gathered to date, in
16 terms of what does Alaska's long-term care system look like,
17 how many people are served, what does it cost, and what are
18 the future trends impacting provision of long-term care in
19 Alaska. And what do we need to do in order to ensure that we
20 have a sustainable long-term care system into the future?

21 So this committee of 20 people -- and I'll introduce the
22 committee members shortly here. We've had lots of discussion.
23 We have met on a few occasions, and these are the three
24 context items of discussions that have often come up. The
25 population bubble, which is our baby boomer generation, is

1 going to create this bubble of increased demand for long-term
2 care services over the next three decades in Alaska. So we
3 have to plan for that bubble and so we've had lots of
4 discussions about that.

5 Our existing system, you know, this is a good thing. Our
6 existing system has a good mix of home and community-based
7 care and nursing facilities. So in comparison to other
8 states, Alaska's long-term care system provides most care in
9 home and community-based settings, so we're very proud of
10 that.

11 And then the need to maintain a mix of services to ensure
12 that our system will serve the increased number of seniors
13 while continuing to contain costs and support independent
14 living for all people of all ages who require long-term
15 supports in the state of Alaska.

16 So those are the three contexts of discussion that we've
17 had often in these committee meetings.

18 So our Long-Term Care Steering Committee, it's a group of
19 stakeholders in long-term care throughout Alaska formed by
20 myself back in the spring of 2011, and as you know, we
21 presented to all of you at the end of April in Juneau to the
22 Health Care Commission. At that time, there were six of us.
23 Well, that's expanded to 20 professionals here in the state
24 and providers and advocates. So the purpose of this group is
25 to plan for the future of long-term care in Alaska.

1 So this is our committee. Denise Daniello, who was
2 present back in April, she's the Executive Director for the
3 Commission on Aging. Nancy Burke, who was also present at
4 that presentation, is with the Alaska Mental Health Trust
5 Authority. Kay Branch, who was present as well, with the
6 Alaska Native Tribal Health Consortium. Karen Perdue was
7 present as well with the Alaska State Hospital Nursing
8 Association. She was just here, presenting. Pat Luby wasn't
9 there, but he has joined our group, and he is with the
10 American Association of Retired Persons, AARP. Diana Weber is
11 relatively new to the group. She's with the Office of Long-
12 Term Care Ombudsman Office. Age Net recommended and referred
13 Rachel Greenberg to our group, so she is a part of that.
14 David Cote was a part of our presentation back in April, and
15 he is the Director of the Pioneer Homes. Sandra Heffern, who
16 is in the audience with Community Care Coalition, she was
17 present in April. Jon Sherwood is kind of like our
18 consultant. He has been with the Department for a long time.
19 He has a lot of knowledge. He's the historian of the group,
20 so we often turn to him for information.

21 And then with the Division of Senior & Disability,
22 myself, Joanne Gibbens, who is the Deputy Director, Kelda
23 Barstead, who oversees our ADRCs, and Amanda Lofgren, who does
24 work with our rural outreach program.

25 And then we have a new member that just joined us, Heidi

1 Frost, who is the Executive Director with the Statewide
2 Independent Living Council. Cyndi Nation is with the Tanana
3 Chief Conference, and Millie Duncan with Wildflower Court.
4 She may be online. She was there with us in Juneau when we
5 gave that presentation. Sharon Scott with the MatSu Health
6 Foundation; I believe she is in the audience as well.

7 There is one -- and I made an error here. There is one
8 person that should be up there and that's Millie Ryan. She's
9 the Executive Director for the Governor's Council on
10 Disabilities and Special Education.

11 So believe we have a pretty balanced group representing
12 all of the interests within long-term care. It's a large
13 group, and you know, we have really great debates and
14 discussions, and we're pretty happy.

15 So what has happened to date? We've convened the
16 Steering Committee, and we've met officially on three
17 occasions and then we've had some subset meetings, maybe up to
18 about six, to talk about a variety of things.

19 Our task was to review previous studies of long-term care
20 in Alaska and compile recommendations. So we brought in, when
21 we met with you back in April, a bag that weighed probably 50
22 pounds with well over 25 long-term care studies. Well after
23 that, we also identified others, but we narrowed it down. So
24 we had to walk through a lot of that stuff, and we narrowed it
25 down to ten.

1 So the matrix that you have in front of you, if I could
2 just describe that to you, on the top of that matrix,
3 identifies those studies that we looked at, those ten studies.
4 Then to the left of that matrix, we have recommendations and
5 overarching themes that we extracted from those studies, so
6 they're to the left. And then we wanted to identify what
7 these studies covered in terms of the overarching themes and
8 recommendations. To the right are our efforts to identify
9 what is actually occurring within the state to address those
10 recommendations. So it was quite a bit of work, but we wanted
11 to get a foundation and a handle on what's going on in the
12 state of Alaska.

13 We have also gathered -- and this is a major exercise for
14 us, but gathering existing data on costs of current system,
15 existing services, and numbers of users. So we did quite a
16 bit of work around that and then gathering costs and
17 demographic projections. Next slide.

18 So although we talked about the definition of what long-
19 term care is back in April, we thought we just should put that
20 up there, and here's another definition similar to what we
21 presented to you back in April. So I don't think I really
22 need to read through that, but just to give you a snapshot.
23 Next slide.

24 Here are some examples of long-term services and
25 supports: direct human assistance, supervision, queuing, and

1 standby assistance; assistive technologies or devices and
2 environmental modifications -- all of this is part of long-
3 term care -- health maintenance tasks, medication, management,
4 and ostomy care; care and service coordination for people who
5 live in their homes, residential settings, or nursing
6 facilities.

7 We wanted to pull this out and to really bold this
8 because it's important to know. Long-term care also includes
9 supports provided to family members and other unpaid
10 caregivers. So we wanted to highlight that. Next slide.

11 So who uses long-term care? I think there is misnomer
12 that people believe it's for seniors, our senior population
13 and so we wanted to be real clear that this is for people of
14 all ages with physical disabilities, intellectual or
15 developmental disabilities, serious mental disorders. All of
16 these groups benefit from long-term care.

17 So who uses long-term care? Families with children with
18 chronic or developmental disabilities, adults with
19 developmental disabilities, seniors with physical and memory-
20 related disabilities.

21 What's interesting to note is, nationally, 60% of people
22 currently receiving long-term care are seniors over the age of
23 65, nationally. In Alaska, only 38% of SDS recipients in
24 Medicaid programs are elderly. So we thought we would point
25 that out as well.

1 MS. AGNEW BEMBEN: So this is my part of the
2 presentation. So as Duane mentioned, we wanted to start by
3 not reinventing the wheel because, clearly, a lot of study has
4 occurred on this topic, and we thought the best place to start
5 a planning process would be to really understand what has
6 already been recommended by many of these very high quality
7 studies that have been done. So if you could go to the next
8 slide?

9 So what we found when we looked at the studies that are
10 included in this matrix, we really found that there is,
11 obviously, a lot of really common themes between what they
12 recommend. There are also pretty varying levels of
13 specificity. Some of them are somewhat general. Some of them
14 get really down into, you know, the details of program
15 requirements, or you know, retooling programs. But basically,
16 we identified these five major goals that came out of these
17 studies.

18 So the first is to maintain and encourage health,
19 wellness, and choice. A lot of emphasis on maintaining
20 independence and choice in terms of where a person wants to
21 live and who they want to be cared -- who they want to have
22 provide care to them. Supporting families and caregivers is
23 really incredibly important because that's where most of the
24 labor force comes from for long-term care; it's from families.
25 Engage consumers in communities, so making sure that

1 communities are accessible and inviting for people to live in,
2 you know, over the full course of their life, no matter what
3 their disability or age. Number four, very, very important,
4 and you'll see this more in the presentation, slowing future
5 cost increases, increasing private investment and the
6 sustainability of the system. And then the last one is just
7 increasing access to safe and quality care. So particularly
8 as we're emphasizing home and community-based services, of
9 course, then that comes with it a responsibility for ensuring
10 the safety and the quality of those settings. Next slide,
11 please.

12 In terms of the overarching recommendations -- and I
13 think this came from the studies, but it was also certainly
14 echoed by the members of the Steering Committee is really
15 shoring up what we would call the lower end of the spectrum of
16 services and long-term care. So ensuring that the home and
17 community-based services are available throughout the state,
18 so that people can be served as close to home as possible and
19 in the lowest level of care appropriate to meet their needs
20 and that makes sense in terms of the cost of care and also in
21 terms of following what we know people who receive long-term
22 care would prefer. So most people would prefer to be in a
23 home and community-based setting; however, of course, we do
24 require nursing facilities for many eventualities, and we need
25 to make sure that those beds are available to meet the demand.

1 However, I think it's interesting. You'll see, a little bit
2 later on, it's interesting to -- there is going to be more
3 study needed to figure out that that really means because I
4 think, as we're prioritizing home and community-based
5 settings, obviously, then we can prevent people, hopefully,
6 from needing that higher level of care, or at least, put it
7 off for as long as possible. Next slide, please.

8 So the studies also, of course, identify specific
9 strategies, and there is -- I'm just going to highlight the
10 main ones here. There is more detail on the matrix, which you
11 can look at further. And then we are still collecting the
12 information on the notes side on the right hand side. So
13 we're having all the folks on the Steering Committee give
14 their updates. So this is really a working document that
15 we're continuing to refine.

16 But the specific strategies that are found throughout the
17 studies are, first, that the public needs to understand what
18 long-term care is and the need for it and also, because of the
19 increase in the senior population, what that's going to mean
20 over the next 30 years.

21 The second one is really important, and this is where we
22 do get -- there is a lot of specific recommendations, many of
23 which the Division is already working on to retool and
24 diversify some of the program requirements in order to contain
25 the costs and also to improve those programs.

1 Coordinating care for individuals, this is incredibly
2 important, having a system that allows people to understand
3 what is available to meet their particular needs. And then
4 coordinating systems of care, and as you know in Alaska,
5 that's always a big issue, since we have numerous sectors of
6 the health system that don't always meet. So that's a big
7 one. Next slide, please.

8 The others we found were improving quality, encouraging
9 innovation. This next one is a big one that we've talked
10 quite a bit about, developing in-state capacity for
11 populations with specific needs and also complex and
12 challenging behaviors. Developing the workforce, which I know
13 you heard about this morning, this is clearly a huge issue for
14 long-term care. Supporting caregivers. And then leveraging
15 technology, and I think this is something that Duane can talk
16 more about, that there is lots of opportunity for using
17 technology in different ways to meet some of these needs.

18 So the next section is going to talk about how long-term
19 care is paid for. Keep in mind that we're using data from the
20 Department, and primarily, what you're going to see is data
21 that relates just to Medicaid. So we really don't have data,
22 and we wish that we did, for the full universe of long-term
23 care and how it -- in terms of how much private pay occurs in
24 Alaska. Even trying to quantify the unpaid services that are
25 provided, we don't have the full universe. So what you're

1 going to see today is really about the state-managed
2 expenditures. Next slide, please.

3 So the way that nationally people pay for long-term care,
4 the biggest one is unpaid family members; 83% of people in
5 2000 live in community settings, many of whom are served by
6 unpaid family members and friends. Out-of-pocket, nationally,
7 18% of long-term care pay for -- sorry, participants pay for
8 long-term care with their personal funds. And again we don't
9 have the state number for that, so that would be an
10 interesting thing to find out.

11 Long-term care insurance is not a great option. Not many
12 people have it. That's another thing that would be worth
13 looking into, how can we make that more available, more
14 attractive for people?

15 The next biggest one is Medicaid, and you'll see that
16 that's pretty much the largest chunk of how long-term care is
17 paid for. And most people, after exhausting their own
18 resources, they become eligible for Medicaid. So that ends up
19 being a big payer. And then Medicare does pay for some time-
20 limited nursing home stays, as long as they are transitional
21 and rehabilitative, and it will also pay for limited home
22 health.

23 So again, this is a national pie chart showing you how
24 long-term care is paid for, again almost half of it by
25 Medicaid, then another big chunk for Medicare, and then out-

1 of-pocket. So those are the largest payers. And again there
2 is a whole lot of unpaid assistance that's not even included
3 in this pie chart.

4 So as Duane mentioned earlier, we do have what's referred
5 to as a pretty balanced system in Alaska. AARP has said, in
6 their studies on this topic, that we have one of the most
7 balanced long-term care systems and that's talking about the
8 balance between nursing facilities and home and community-
9 based care. But again, I think the thing that the Committee
10 has really identified as being the topic that needs to be
11 addressed is that, with the big wave of seniors coming in, is
12 it going to sort of wreck that balance, is it going to blow
13 the system? So that's what we're emphasizing we need to
14 prepare for.

15 The next slide tries to give you a graphic of what a
16 balanced system looks like, and I just want to take a second
17 just to identify the things here.

18 So at the very center is the individual and their
19 caregiver and that's really to emphasize that they are the
20 decision makers about where and how they receive long-term
21 care. Within that blue bubble are the home-based services.
22 So these are all the things that are available in your home to
23 provide long-term care assistance. Then in the green band
24 around, these are ones that are or should be, perhaps,
25 available within each community. And so there is a range of

1 different services available there. And then you'll see, to
2 the outside of that ring, you have the more institutional
3 settings. So you have nursing home, hospital, and assisted
4 living in a larger institution, not so much in a private home.
5 And the arrow that says rehabilitation on it, that's to
6 emphasize that -- I think, a lot of times, you find that
7 people think, when I get old, I'm just going to end up in a
8 nursing home, perhaps for ten years. I think, ideally, the
9 system -- you might need to be in a nursing facility at some
10 point, but if possible through rehabilitation, you can go back
11 into a lower level of care. That's not always possible, but
12 that's -- I think, when we think about a balanced and kind of
13 an ideal system, that's the emphasis. And then this circle at
14 the kind of the nexus point there at the bottom, that's where
15 this really -- this importance of coordinating care comes in
16 and that's occurring through Centers for Independent Living,
17 Aging and Disability Resource Centers. The Traumatic Brain
18 Injury Group also provides that kind of resource navigation.
19 So that's really what allows people to connect with these
20 services and to connect the services, so that they get the
21 care that they need and that's a very critical function.

22 So how do we compare to other states? According to a
23 very recent survey by AARP, we rank number one in terms of
24 choice of setting and provider and also quality of care and
25 quality of life, but unfortunately, we rank number 41 for

1 support of family caregivers and number 43 for affordability
2 and access. So we're doing some things really great and some
3 other things not so great.

4 So the next slide is, again, keeping in mind that this is
5 just looking at state and Medicaid expenditures and
6 recipients, and I also just want to emphasize that this is not
7 a common unit through here. So for example, on the far left,
8 we have people receiving services through an Aging and
9 Disability Resource Center. They're getting information and
10 referral, that kind of coordination that I was describing.
11 And those Centers are able to serve quite a lot of people,
12 15,600 recipients, for only \$30 a person, but again, that
13 could just be, you know, one hour of service.

14 As we go to the right, we see, increasing in intensity
15 along the continuum of care, services funded by senior and
16 community-based grants, assisted living, which is funded by a
17 variety of state programs, to nursing facilities and then home
18 health and hospice. And what this is really -- the point this
19 is really just trying to make is that the more people that we
20 serve at the lower end of the spectrum, and hopefully, keep
21 them there, we avoid the higher levels of expenditures at the
22 more intense level.

23 So in Alaska currently, this is -- I believe we're using
24 2010 numbers here from the Department. About 50,000 people
25 were benefitting from state-funded long-term care services,

1 for an expenditure of about \$422 million annually. And again
2 confirming what we have said earlier, 78% of those funds are
3 being spent to support community-based care, and 97% of the
4 recipients are receiving their care in non-institutional
5 settings.

6 So just to give you a breakdown of what that looks like,
7 this is just showing you, again, the state-managed
8 expenditures for home and community-based care, nursing
9 facilities, and then this little wedge for home health and
10 hospice. And then to the right, the pie chart is breaking
11 out, for you, how those home and community-based care
12 expenditures are divvied up. So 44% is on home and community-
13 based waivers, so that's Medicaid waivers. And then we have
14 personal care assistance, 26%, and then a variety of grants
15 that the Division manages that provide kind of a host of
16 services, senior centers, meals, transportation, general
17 relief. That's used a lot for people who are in assisted
18 living. So a variety services are funded through those state
19 funds.

20 And then on the next slide, we have a breakout of the
21 program recipients. So here's where you see that 97% of the
22 recipients are being served in home and community-based
23 settings, and you'll see how that's broken out on the right.
24 So a lot of it is through these senior and community-based
25 grants, general relief, residential grants, the ADRCs that do

1 that care coordination, and then we also have the community
2 and developmental disability grants, personal care assistance,
3 and again, the waivers. So that shows you how many people are
4 served in each of those -- by each of those programs.

5 So as we've been mentioning, there are some, you know,
6 kind of daunting future trends that I know you are already
7 aware of, but just to sort of emphasize them again, there is
8 this increase in senior population, even though, of course,
9 long-term care serves people of all ages, we have one segment
10 of the population that is growing much faster than the others.
11 So again our question is, how will this increase really affect
12 care for all the people who benefit from long-term care
13 services? Will there be adequate care? Will we be able to
14 maintain that balance? And then added to that, of course, we
15 have the increase of costs for health-related services, which
16 impacts pretty much everything, right?

17 So the next slide shows you some different age cohorts,
18 and this is Department of Labor projections to 2034. And
19 you'll just see, over in that right hand column, the annual
20 growth rate for 65 to 84 is 6%, and then for 85 and older,
21 they're growing at 8% a year. And then compare that to the
22 younger folks, you'll see where we're -- how different we'll
23 be in 20 years. It's pretty interesting when you start
24 looking at it.

25 The next two slides are going to show you how these

1 different ages are distributed across the state, and this is
2 2010 figures. So this is the 65 to 84 population. This is
3 people in that age cohort today. So you'll see that we have
4 this hot spot, as we like to call it, in Anchorage. Actually,
5 I thought I switched these. Oh, that's right. I switched
6 them in mine, but not in yours. Anyway, I thought it was more
7 interesting. Can we look at the next one first?

8 So this is people who are 85 and older today, and you
9 know, Anchorage has the greatest concentration of people in
10 that age category. And then you'll see that, in, basically,
11 Southcentral and then Yukon-Koyukuk, we have, you know, higher
12 levels of population in that age category. Then if you look
13 at the people who are 65 to 84 today -- so these are the folks
14 who are going to be 85-plus over the next 20 years, that --
15 again I mean, that part of the state has high numbers, but the
16 whole state is going to have a lot more seniors. I'll just
17 keep saying that over and over again as we go forward.

18 And then this is, again, looking at the different -- this
19 is all -- this is seniors. So the lighter color is the 65 to
20 74 year olds and then 75 to 85 and then 85-plus. So you'll
21 just see how they're all growing. And I always think it's
22 interesting to note that it is a boom. You'll see that the
23 trends start to go down. So we also don't want it overbuilt.
24 I think that's the other piece of this. We want to make sure
25 there is flexibility in the system, so that we're not

1 overbuilt as the boom passes through. We can go to the next
2 one.

3 And then again this is just to look at the proportion of
4 long-term care recipients who are seniors as compared to those
5 who are children and adults. Currently, 38% of -- and this
6 is, again, just using Medicaid numbers. So 38% of recipients
7 of long-term care funded by Medicaid are seniors. In 2034,
8 that will be 55%.

9 So nursing facilities. Right now, we have 15 nursing
10 facilities with 708 beds. And this is something that Jon
11 Sherwood called to our attention. I think it's very
12 interesting that, even though our senior population has
13 tripled over the past 20 years, we actually have fewer nursing
14 facility beds now than we used to. So we've consciously made
15 this movement away from institutional-based care. And I think
16 the question is, how long can we keep that up? I mean, you
17 know, that's a good trend. We also know, however, that, in
18 the last five years, including this year, we're going to lose
19 about 100 more beds. So I think that's a real open question
20 for the Committee is, what role will those facilities play in
21 long-term care, and how do we plan? How do we gauge the
22 demand for those?

23 MR. MAYES: So this next slide is -- we call it the Cost
24 of Maintaining the Status Quo, really doing nothing other than
25 what we have in place today. And you will note, up there to

1 the left in 2010, it's a combination of expenses. Our waiver
2 program through the Division of Senior Disability Services, we
3 have our four waivers, so that subtotals \$192 million and then
4 we have some other costs there from nursing home to personal
5 care assistance and home health/hospice. So when you look at
6 that figure, 383,000 for 2010, and you kind of project into
7 the future to 2030, we're looking at \$1,886,000,000 and so
8 that is alarming, and as a group, we were really kind of
9 stunned by that. Next slide.

10 So where do we go from here? How are we going to be able
11 to sustain long-term care for the next 20 years? Steering
12 Committee Recommendations. We want to continue with the Long-
13 Term Care planning process, but divide it into two streams.
14 One stream would be an internal focus that I would share
15 specific to the Division of Senior Disability Services. The
16 Division is huge, and there are some initiatives that we're
17 moving forward with. When you look at some of those
18 overarching themes and recommendations from the studies that
19 we reviewed, actually there are some things that we're doing
20 within the Division. So as a Director, that would be my focus
21 to move forward with that.

22 The other would be an external committee, a committee
23 focusing on broader system and education, educating the
24 public. Next slide.

25 So in our discussions and debates, the questions that we

1 would need to tackle as a committee are, how can we better
2 support family members and other unpaid caregivers? We've
3 talked a lot about that. How do we incentivize the private
4 and non-profit sectors to develop and manage quality home and
5 community-based services and assisted living facilities,
6 especially in rural Alaska? I think that's important. How do
7 we meet the need and high demand areas of the state, such as
8 Southcentral Alaska? And how do we incentivize care for
9 people with complex and difficult behaviors? And you heard
10 this morning, who will be the workforce and how we recruit,
11 train, and retain them? So those are some of the questions
12 that, as a Committee and having these two subsets, that we
13 would need to address.

14 So I'm bringing forward a recommendation to the
15 Department, to the Commissioner that we break into two subsets
16 and that I continue on and move forward with addressing those
17 things that we've -- those initiatives that we initiated
18 within the Division of Senior Disability Services. Next
19 slide.

20 So that's our presentation. So we're available for
21 questions. You have 20 of us that can, hopefully, respond.
22 Any questions?

23 COMMISSIONER CAMPBELL: I hope I don't look like the
24 north end of a southbound horse here, but there are a lot of
25 things I don't understand.

1 One thing I do understand is the total cost of
2 institutional care, nursing homes and other facilities, but I
3 see the wide range of costs in here in one of the flags. And
4 I haven't had a chance to go through your matrix, but there's
5 a wide divergence of costs for the home-based and all these
6 sorts of things, and of course, your statistics prove that's
7 just been an exponential explosion in numbers of people and
8 also dollars, but I'm also wondering how many of these people
9 in the personal health/personal care business are also getting
10 other Medicaid services or services in other public sectors,
11 so that the apparent divergence in wide-ranging costs between
12 institutional care of a nursing home versus what you see here
13 -- pick a number -- if you added in housing and transportation
14 and all these other things, how narrow would that gap get
15 between true institutional long-term care and the total cost
16 of providing these other things? I don't see anything totaled
17 that way here, and admittedly, haven't had a chance to go
18 through your matrix.

19 MR. MAYES: Right. Right. Anybody in the crowd who
20 wants to give it a shot? Jon?

21 COMMISSIONER ERICKSON: Jon, could you introduce yourself
22 for the Commission?

23 MR. SHERWOOD: Yeah (affirmative). For the record, I'm
24 Jon Sherwood with the Department of Health and Social
25 Services. I don't think we've done a comprehensive

1 comparison. When you talk about the room and board, it's
2 certainly true that room and board, if you were in a community
3 setting, is not paid for through Medicaid. The assistance
4 that's available for room and board, when is assistance is
5 provided, would be typically SSI, Supplemental Security
6 Income, which is around -- and there are probably know the
7 exact number better than I do, but around \$700 a month. And
8 then the Adult Public Assistance payment can go on top of
9 that, up to \$363 a month. Typically, individuals have some
10 degree of income themselves, and they don't receive that full
11 amount in assistance. So that's roughly, you know, in
12 ballpark figures, about \$1,000 of potential assistance for
13 that. A very small amount of food stamps in those cases would
14 be possible. You know, the sources -- SSI, the primary
15 source, is completely federal. The APA payment is entirely
16 state. APA pays on top. It's the supplement. So the larger
17 share, if someone has no income, would come from the federal
18 government there. Food stamps is a federal benefit. Then we
19 do -- I mean, people do receive other Medicaid services, and
20 as you're familiar, some of those services might be included
21 in the all-inclusive rate of a nursing home. They might be
22 provided separately.

23 For our waivers, we have to determine cost neutrality
24 every year for the federal government, and we consistently
25 come in well below the comparison of total Medicaid

1 expenditure for institutionalization versus non-
2 institutionalization. I don't have the data in front of me,
3 so that I can give you some, you know, more explicit examples.
4 It would take some analysis to figure out average levels of
5 assistance in these populations.

6 COMMISSIONER CAMPBELL: I guess my concern was that you
7 might get a false picture that community-based services are
8 much cheaper than they might -- unless you had it grossed up
9 so that that margin would narrow.

10 MR. SHERWOOD: I think your point is that it's not a pure
11 apples-to-apples, if you take just the average cost of nursing
12 home versus the average cost of waived services or the
13 average cost of personal care and make that kind of
14 comparison. The data we've seen when we done the analysis
15 does show that it's less expensive, but in individual cases,
16 you know, there are some situations where it's not always, but
17 on the average, it is less expensive and the degree varies by
18 the kind of population served.

19 COMMISSIONER ENNIS: Duane and Keith, I would like to
20 refer back to the statistics that say that about 80% of the
21 care is provided in the family home, and I think that needs to
22 be put into this mix. For individuals who live in the family
23 home that receive community-based services, they are generally
24 short term adult day center services, some respite, some in-
25 home support, Meals-on-Wheels, et cetera, fairly low cost and

1 not intensive kinds of service. And I know, as an agency that
2 provides many of those services, we do look at the income
3 levels of the individuals and many of them, you know, are
4 self-sustaining, their lives and their family home. It's a
5 piece we don't think about, but they are receiving very low-
6 cost services, and the whole idea is to keep them in the
7 family home.

8 MR. MAYES: Lowest level of care.

9 COMMISSIONER FRIEDRICH: I want to thank you all.
10 Reflecting back to your last presentation, we had a number of
11 questions for you, as I recall, and kudos because I think you
12 answered pretty much all of them, and bringing in the more
13 detailed analysis got beyond the bag of studies so that this
14 changes this from "here is a problem, solve it" to "here are
15 some clear recommendations and a way ahead." So my
16 compliments to you for that.

17 One part of this that I suspect your group will tease out
18 as you get into this more deeply is the role of the individual
19 in thinking through the requirement for long-term care, and
20 we've touched on this with different presenters along the way,
21 but there's -- you know, we keep referring to the fact that
22 the pie is unlikely to get any larger. So whatever we choose
23 to spend in one area will come at the expense of another area.

24 As you all look at this, I would ask that you consider,
25 at what point do we educate the consumer, the health care

1 consumer, long-term care consumer to say that, you know, these
2 are the things that you may well have to pay for yourself,
3 should you desire to have them? There seems to be an implicit
4 assumption in many minds, among those with whom I interact,
5 that someone will provide all these services for them down the
6 road, and I think the answer is going to be that that menu of
7 services that are provided by the government will decrease
8 over time, not increase. So an educational component for
9 consumers may be one of the more valuable programs that you
10 could offer as we move forward with this.

11 The second part, going back to Keith's point there, is
12 that, as you continue to flesh out these costs here a little
13 bit, the in-home care piece absolutely seems to be intuitively
14 the way that we want to go, and I say we on the federal side.
15 Certainly with our TBI, PTSD, and other long care recipients,
16 we would much prefer to get them in there. To whatever extent
17 you can help us understand how most efficiently and
18 effectively to provide that care here in Alaska would be
19 extremely valuable because we've struggled with that, with the
20 mix of services that are available today. So I thank you very
21 much for the work you've done, and I ask for your help in
22 those two areas.

23 MR. MAYES: Well, you're welcome. We were hoping to
24 provide you with more actually, but you know, six months, and
25 we have other responsibilities as well.

1 CHAIR HURLBURT: Pat?

2 COMMISSIONER BRANCO: One of the pieces of information --
3 and again, commendable work in six months. This is
4 incredible. One that caught me by surprise, sort of, was way
5 back on slide 18, the reference to the long-term care
6 insurance and individual responsibility. And the reference
7 here is expense, and I don't know if that's really accurate,
8 so I'll use myself as a perspective. I'm probably never going
9 into a nursing home, so he says today, and so I don't need any
10 long-term care insurance. So is it really the expense or is
11 it the culture because I -- I mean, I could ask the question
12 of Jeff. I don't think the premiums are very high, and
13 they're probably not a block, but there is a cultural piece
14 and I'd love to get your take on that because it just hit me
15 as I read it.

16 MR. MAYES: I'm going -- actually, we've had a lot of
17 discussion about that in terms of expense and then what is
18 provided in terms of coverage, but.....

19 MS. AGNEW BEMBEN: Well, maybe just even prior to that.
20 We did try to look into it. It's not very available. I mean,
21 it's just interesting. Even to try and figure out what is
22 available, what does it cost, how many people have it, it's
23 not clear how to get that information even at this point.
24 It's just something that isn't -- I mean, I think it should be
25 at the top of our list really because it's, like, we all

1 should be getting it, right, but I mean, does anyone here have
2 it? But I think Kay knows more about this. No? I feel like
3 we talked about it in our meeting, and you talked to Joanne
4 about it. It's not something that anyone has the information
5 readily available.

6 MS. BRANCH: No. We really don't have that information.
7 It would be interesting to see a show of hands though of the
8 number of people in this room that have long-term care
9 insurance today.

10 CHAIR HURLBURT: Yeah (affirmative). I have it through
11 the employer that we share, for the last 18 years, that will
12 cover \$40 a day. So that will buy my salt and pepper in a
13 long-term care facility.

14 MR. DAVIS: So I'm not in this business of long-term care
15 and we don't sell it and we don't provide it, but I do know a
16 little bit about it. And no; I don't have a policy, but I
17 know I should. But I do think, to your point, Thea, it
18 probably should be on the top of the list.

19 When we talk about public, you know, education, the
20 people who do know something about it -- and I refer you to a
21 guy by the name of Bob Satterwaite (ph); he's here in
22 Anchorage. He knows more about long-term care than in the
23 market than anybody else in Alaska, and I'm sure he'd be happy
24 to talk with you about it. But what I do know from Bob is
25 what you're really doing is you're insuring your estate. I

1 mean, there's a point there that says, you know, most people
2 get it from Medicaid after they spend down all their
3 resources. Well, that's nice, but the person you leave behind
4 has no resources any longer. So it really is -- it's
5 expensive, but it's not unaffordable for most middle-class
6 people, if you buy it early enough, and it doesn't -- modern
7 long-term care doesn't pay \$40 a day. It's really a pretty
8 great benefit.

9 So I will say that, you know, do as I say, not as I do.
10 I did convince my father that he needed it and so he had a
11 policy that was a piece of mind for all of his children, until
12 he passed away. So anyway, I think that is something that
13 should -- bears further research and further emphasis.

14 MR. LAUFER: I don't know how many people were at the
15 State of Reform conference last -- was it last Friday? I
16 forget, but Dr. Kiessling, who is a family doctor and is very
17 to the point and direct about this, addressed some of these
18 issues, and basically you know, there was a great thing on NPR
19 about this as well. The boomers are delusional about their
20 capacity to live healthy long lives without disability,
21 without pain, and this is widespread.

22 The other thing is long-term care insurance policies are
23 not subject to the same rules as health insurance and can
24 exclude you, and I had to write a series of letters recently
25 for someone who was smart enough to apply. But years ago, she

1 had been concerned about memory lapses and used that term,
2 which was an immediate disqualifier, even though it was just
3 menopause, and she went through a full two days of
4 neuropsychiatric testing and everything. I still had to write
5 a letter that said, you know, this is a healthy worried person
6 and not an unhealthy person, and she's had time to develop
7 dementia, if she was going to.

8 But you know, it all comes back to the same -- I asked
9 this question at the State of Reform, can the boomers live
10 within their means? And I doubt it because what I look at
11 here is my children, who are too young to vote but are going
12 to be footing the bill for this, and it's ridiculous. No way,
13 you know. How could we pay almost a billion dollars for PCAs
14 for people living -- you know, usually relatives at home? I
15 don't get it, you know. My father has Alzheimer's disease.
16 I'm caring for him. My family is caring for him. We modified
17 our homes. I took care of him last week, and I bought him
18 dinner. Nobody is paying me, and where -- why can't other
19 people do that? That's a good question. And actually if
20 there were ready support and pay, we might apply. So I don't
21 know. I know Wes is thinking this, but where does personal
22 responsibility begin and how much of a bill are we going to
23 leave for the next generation?

24 COMMISSIONER DAVIDSON: Well you know, I really can't
25 resist anytime we talk about personal responsibility. I think

1 I'm really sensitive to that notion of personal
2 responsibility. I think there's a notion of personal
3 engagement, which is very different than the whole notion of
4 personal responsibility. It's not as accusing, and I think
5 that educating people and getting people to understand what
6 the variables are in their health really is a very different
7 thing than talking about their -- assuming that they are not
8 personally responsible simply because they choose to live not
9 like we do or they can't live like we do, et cetera.

10 But the other thing is, I mean, we all have variations of
11 personal engagement and personal preparation for our health.
12 I mean, every time we have lunch here, how many of us get up
13 to go wash our hands before we walk through the food line? I
14 mean, we're all health people. We're all health care people.
15 And it's sort of like you go through the notion of ask the
16 question, how many people in the room have long-term care
17 insurance? Well, does having children count? No, not really.
18 When I do think about long-term care needs, I notice that I'm
19 a lot nicer to my kids on the days that I'm not.

20 But I guess I wanted to go back -- as an aside, I'll go
21 back to my original point, which was that I think you made a
22 point, Thea, in your comment. There was a comment that you
23 made that moving -- people who don't -- we're moving away from
24 residential long-term care services, which is really a great
25 trend, and I don't think that's necessarily an accurate

1 statement. I think it's a great trend for those who don't
2 need that level of service, but there are a lot of people in
3 this state who do need a higher level of service where that
4 service simply isn't available and that's true in many of our
5 rural communities. It's true in many parts of the state who,
6 unfortunately, don't have even home and community-based
7 services. And then you have people who are coming into our
8 facilities who may have a traumatic brain injury who simply
9 cannot go back to their home community because (indiscernible
10 - speaking in Native tongue), or pick any rural community,
11 simply doesn't have the service so that they can go back to
12 that home. And those are all things that really make a
13 difference.

14 So I guess I'm wondering, in terms of capturing some of
15 this information, I think the other part that isn't
16 necessarily captured is the hospital days of a person who is
17 there simply because there is no other place to send that
18 person, and I think that's -- I don't know if you've
19 calculated that into your costs, but I think that's the other
20 -- like the 85% or 83% of family members who care for people,
21 the other cost that we don't really ever consider is the cost
22 of in-patient facilities where they can't send them anywhere
23 else.

24 Or the other thing that happens, which we've seen in our
25 facilities, is the cost of caring for people who have dementia

1 or who may be violent who get kicked out of facilities, and we
2 have cases where people have been literally dumped in our
3 emergency room and they say, you know, congratulations; we
4 can't care for them any longer. Here, they are waiting for
5 you in your emergency room. So I think some of those other
6 costs are things that we simply -- I don't know if we're
7 calculating that into this cost, or how are we sort of
8 accounting for those anomalies when they occur?

9 MS. AGNEW BEMBEN: Just to explain my comment that you
10 referred to, really what I've seen, especially in rural areas
11 actually, is that, right now because of the absence of home
12 and community-based care, sometimes people stay in higher
13 level care perhaps longer than they would otherwise because
14 there isn't an appropriate place to refer them out. So that's
15 what I was referring to there. I totally agree with you, that
16 they're absolutely needed for folks that have those needs. So
17 that's what I was referring to there.

18 On the question of the cost of swing beds, we have the
19 Medicare segment in the national figures that we gave you. We
20 don't have that included in the state data, and I'm probably
21 being kind of fuzzy-headed on that. I'm not sure, because
22 that would be paid for through Medicare generally, I think,
23 the swings beds.

24 COMMISSIONER DAVIDSON: Or else it's uncompensated care.

25 (Pause - indiscernible background conversation - away

1 from mic)

2 MS. BRANCH: I'm Kay Branch with the Tribal Health
3 Consortium. I think what Valerie is talking about is people
4 who end up in our hospital or any hospital and are non-paid.
5 We cannot get any reimbursement for them, but that is still a
6 cost to the hospital. Swing bed is a specific designation
7 that's only available to rural hospitals and only a few take
8 advantage of it at this time.

9 COMMISSIONER BRANCO: But you can't safely discharge
10 them.

11 MS. BRANCH: Right.

12 MS. AGNEW BEMBEN: We do have figures from the long-term
13 care ombudsman about people with complex behaviors who end up
14 at API, and we could get you those figures, slightly different
15 again.

16 COMMISSIONER KELLER: This 83% number, unpaid family
17 members, Noah, I also -- our family is bigger is because -- or
18 I mean, our house is bigger because of care for now deceased
19 family. But I can't help but wonder if that 83% number, has
20 there been any projections on it? I mean, I may not even want
21 to go there with a question, but you know, the families are
22 deteriorating in our country. I mean, half our children now
23 have two parents, and what is that going to do to that 83%
24 number? And if we take the role, you know, that the
25 government is the ultimate provider, which we obviously have,

1 you know, I mean -- just this is spooky stuff, to me.

2 COMMISSIONER ENNIS: I have another question related to
3 the 83% number. Are there any national reports on the length
4 of time those 83% of families care for a loved one with
5 Alzheimer's disease or dementia or disabling condition or do
6 we have any trends in Alaska regarding the length of time a
7 family cares for a senior? I think it would be interesting to
8 know that. For those of you who have provided that care --
9 and I have as well in my family home, I don't think you can
10 understand the demands and the changes that it creates over a
11 period of time providing that care, and you really do need a
12 lot of support. You know often, that comes from the extended
13 family, but if you don't have that, it's not there. So I do
14 think -- I just whole-heartedly support the question how can
15 we better support family members and other unpaid caregivers
16 in Alaska if we want to sustain that 83, which I think that's
17 a very good question, Wes, or at least, replicate that in
18 Alaska. So I think to dive into that percentage in Alaska
19 would be important to know when the breaking point is for a
20 family. It's not the health or the progression of the disease
21 for the senior. It's simply the family can't do it anymore.

22 MR. MAYES: Right. We have talked about that quite a bit
23 in our committee meeting, several meetings where we had talked
24 about that. I remember, last year during the legislative
25 session, being asked that question several times. So 83% is

1 huge, but I do understand the demands that that can bring to
2 families.

3 COMMISSIONER LAUFER: When Shelley spoke to us before,
4 she was talking about out-of-the-box, you know, our thinking.
5 You know, other countries have done that. I lived in Germany
6 for several years. You have what's called Dentz (ph). You
7 have responsibility as a young adult to provide public
8 service, and in exchange for that, you get higher education,
9 and we could do that. You know, a family caring for somebody
10 with Alzheimer's could really use a break, and there is a
11 healthy young person who does it. They do it for,
12 essentially, nothing, and in return for that, they are
13 rewarded socially with an education which is prohibitively
14 expensive for an increasingly large group of people. This is
15 socialism again. But you know, these are the questions.
16 Again it's like the classroom where the teacher spends 95% of
17 their time on the problem child who is never going to grow up
18 to be terribly productive and the students who have incredible
19 potential languish. You know, it's not the government that
20 provides these services. It's taxpayers, and there are fewer
21 of them with a lower and lower capacity to pay taxes. I don't
22 -- that's out-of-the-box.

23 CHAIR HURLBURT: Emily, you had another comment, then
24 Paul.

25 COMMISSIONER ENNIS: I did want to just mention that the

1 state of Alaska does have an excellent program to support
2 families providing care in their home. It's the National
3 Family Caregiver Support Program, and a few non-profits around
4 the state have received grant funds to implement that, and it
5 does make a big difference. The services of that grant are
6 not directed necessarily at the senior, the family member, but
7 at the caregivers, both counseling support, time away,
8 respite, education, et cetera, and this is proving to be very,
9 very beneficial. Again we don't know how we'll extend the
10 time a senior can remain in the home, and I think that would
11 be an interesting study.

12 COMMISSIONER FRIEDRICHS: Thank you, Mr. Chairman. You
13 know, many of you have touched on the part of this that I
14 struggle with as well. So the VA was directed by Congress to
15 implement a caregiver support program as well, and it's been
16 rolled out over the last year. I think it's too early for us
17 to judge the impact of that, but clearly, we know already
18 there is a significant cost associated with it and that impact
19 question is the million dollar question. So if the pie gets
20 no bigger and you have to choose between perinatal services so
21 that we go from having the highest rate of children who die in
22 the first year of life of any industrialized country in the
23 world to a slightly lower rate which would yield more citizens
24 who can get jobs and pay taxes or we take that same money and
25 we spend it on end of life care, or you know, there was a

1 great study that came out last week that showed that of
2 seniors who die, I think, 25% or 27% had had surgery within
3 the last year of life. You know, as a surgeon, I was very
4 taken aback by that, and as a urologist, really taken aback by
5 that.

6 These are the sorts of really difficult questions and
7 that's why, you know, my comments may have been a little too
8 diplomatic. You know, at some point, we will have to choose.
9 Do we invest money in those who will become paying citizens or
10 do we invest money in those who have been paying citizens in
11 the past? I cannot conceive, as we look at all of the
12 programs that have come before us, that the state of Alaska or
13 our country can continue to pay for everything and more of
14 everything for everybody and that's the philosophical
15 discussion, as we get into writing our report, that I know I'm
16 struggling with very much, but I want to thank you all again
17 because you've given me a much better -- much clearer
18 understanding now of the long-term care piece of this, and
19 especially the fact that, here in Alaska, so much of this is
20 not just an elder care issue. It's a much broader issue to
21 address. So thank you again. End of my pontification.

22 CHAIR HURLBURT: I kind of reacted, too, Paul. I
23 wondered how the other 65% got away from us. Any other
24 comments or questions? Jeff? Okay. Thank you all very much.
25 Thanks for being so responsive to the requests and the

1 questions that came from the first presentation. It was very
2 helpful. So I thank all your group. Let's go ahead and take
3 about a ten or 15-minute break now. Then Deb is going to get
4 us set up for our next conversation, and we'll move into that
5 a little bit early. So it's 2:30 now.

6 2:30:00

7 (Off record)

8 (On record)

9 2:30:11

10 CHAIR HURLBURT: If we could get back together again, and
11 what we want to do for the next hour-and-a-quarter or so --
12 then we've got a little flexibility. We'll see how it goes
13 here, but we want to talk about the draft of the 2011 Findings
14 and Recommendations, which will be presented on January 15th
15 to the Governor's office and to the Legislature. So that will
16 be a major focus for us over the next three months or so to
17 have it accurately reflect what we've talked about, what
18 conclusions we've come to, what our recommendations should be.

19 And then whenever we end with that, Commissioner Bill
20 Streur is going to come and give us the update on the
21 Affordability Care Act. So Deb, I'll turn it over to you.

22 COMMISSIONER ERICKSON: I think what we're going to do is
23 take a few minutes just to frame our conversation and maybe
24 talk a little bit more about Allen's question of an hour-and-
25 a-half ago or so, too, as we move forward with finalizing our

1 draft Recommendations that we have drafted so far, but
2 understanding they're still in draft.

3 So I'm going to take a few minutes just to provide some
4 review for most of the Commission, make sure Allen is up-to-
5 speed on kind of where we're at and the context, for the
6 audience and anybody else listening in, on what the Commission
7 is about. But before I do that, I want to talk about our
8 process a little bit here for the rest of the meeting. Except
9 for some time at the end of the day where we're going to be
10 going over kind of a status report of what's going on related
11 to the federal health care reform, the Affordable Care Act,
12 specifically in Alaska, we have all of the rest of our time,
13 including all morning tomorrow, devoted to Commission work
14 session time, conversation. So the whole rest of this
15 meeting, except for this little bit of time at the end of the
16 day on the Affordable Care Act, no more presentation, just
17 work. And if we work efficiently and effectively, we might
18 even get to go home early tomorrow.

19 So we have a little bit of time for that, and what we are
20 looking for in terms of an outcome for the end of our meeting
21 by noon tomorrow is draft Finding and Recommendation
22 statements that you all are comfortable enough with at this
23 stage in the process to release to the public for public -- a
24 more formal public feedback process, and we will devote the
25 month of November to that, and we'll come back in December

1 together and finalize those statements for the final report.
2 So that's what we're looking for in terms of outcome.

3 One other outcome that we are shooting for, for the end
4 of the meeting tomorrow, is also what we would like to put out
5 in draft form is a list of those issues that we want to study
6 and develop recommendations on during 2012. So we also will
7 release to the public our kind of preliminary agenda for the
8 main point issues that we want to study next year, to get
9 their feedback on that as well. And so we'll spend some time
10 on that tomorrow.

11 So those are the two outcomes we're shooting for, for
12 this meeting. And just a little caveat. Hopefully, we'll
13 have most of the things, especially those Finding and
14 Recommendation statements that we've already been working
15 together on for a while, close enough at the end of this
16 meeting that you're going to be comfortable with them and
17 approve them for release to the public in draft form at that
18 point. There might be some new things that we come up with at
19 this meeting that we might need to do some wordsmithing on and
20 have one teleconference in a week or two just to firm that up,
21 so you're comfortable with anything that's new that comes out
22 of this discussion. So just with that little caveat, that's
23 where we're at.

24 So does anybody have any questions about how we're going
25 to spend our time the rest of this meeting and we're hoping to

1 get out of the end of the meeting?

2 Well, I'm going to try to spend no more than just a few
3 minutes reviewing quickly our charge, and actually, I don't
4 think I killed enough trees yesterday making printouts for the
5 audience. This PowerPoint presentation that I'm going to be
6 using right now with the Commission is posted on our website,
7 and it's titled Meeting Discussion Guide. I don't have copies
8 of it here in the audience, but you folks will be able to see
9 it on the wall. One of the things that I think I did make
10 copies of for the audience here is the Word documents that
11 have our current draft Findings and Recommendations, which is
12 what most of the body of this document is, this PowerPoint
13 presentation. But if folks online want to try to follow
14 along, you're not going to be able to see what I'm doing as
15 I'm typing notes into this PowerPoint, but the current
16 PowerPoint presentation is posted online as the Meeting
17 Discussion Guide.

18 So starting with the Commission's Charge, this is
19 directly from our purpose statement in our statute;

20 "The purpose of the Commission is to provide
21 recommendations for and foster the development of a
22 statewide plan to address the quality, accessibility, and
23 availability of health care for all citizens of the
24 state."

25 And just a quick analogy, this is one that our friend Don

1 Berwick is fond of using and is helpful for me, too, to think
2 in bigger terms about what we're trying to achieve for our
3 health care system and how we're going about it, but he
4 compares it to a car. And if we have a vehicle that we want
5 to be more efficient, get better gas mileage, go faster, that
6 we don't just pour more money, which is maybe what we're used
7 to doing -- you don't put more gas in and get a faster car
8 that gets better gas mileage. We have to design a whole new
9 car and that's really what we're about is not just kind of
10 tweaking around the edges or figuring out where we need to
11 invest more resources, that we really need to think in
12 different ways about how the health care system is working so
13 that it's more efficient and effective.

14 So in accordance with our charge, what we have been doing
15 and what we have done is envisioned a future for Alaska's
16 health care system and a transformed health care system for
17 Alaska, and we've kind of laid out a path for moving in that
18 direction and a general strategy for attaining our vision.
19 And what we're focused on now is trying to identify some
20 innovative approaches for state policies that can help
21 Alaskans stay healthier, but at the same time, to the extent
22 that when they get sick, health care is affordable and
23 available and it's safe and efficient and effective.

24 And we're also continuing -- as we work on identifying
25 policies that will help us to attain the vision, we are also -

1 - another aspect of the work we're doing is trying to dig in
2 deeper and make sure that we understand what it is about the
3 current system, what are the conditions of the current system
4 that are keeping us from attaining that vision today, what are
5 the problems, so we're better informed and are able to make
6 sure that the policy recommendations are well-informed.

7 Quickly, we've used this diagram now for a while, but
8 that just lays out in a little bit more graphic form what I
9 went over. We've developed our vision. We're continuing to
10 work on describing the current condition of the system. We've
11 identified the importance of the foundation for a transformed
12 health care system, statewide leadership, a strong workforce,
13 and the health information infrastructure, and we're building
14 on that our transformation policies. I'm going to keep over
15 all of these that really are focused on how can we enhance the
16 consumer's role in health, and two aspects of that, policies
17 that we're focused on, are how we can support health care to
18 be more innovative and more patient-centered and how can we
19 support individuals to live healthier lifestyles. So that's
20 all just kind of a review and context for what we've done so
21 far and what we're doing.

22 Just because, more and more -- I don't know why I didn't
23 think it would happen more and more because it happened a lot
24 from the beginning, but lots of contact from -- we have a
25 large ListServ at this point. We have about 550 people on it.

1 The most questions -- my perception is the most questions I
2 get specifically about the Commission and about getting on the
3 ListServ come from -- seem to come from industry, lobbyists,
4 and a significant number from outside Alaska, and it's not
5 just because of that, but just to help us to stay focused, I
6 think it's important to help define our scope, not by just
7 what we're doing but what we're not doing, and this, I think,
8 will help -- maybe help get at your question earlier, Allen,
9 what we're not doing, what is beyond our charge.

10 It's not our responsibility to oversee or provide
11 guidance specifically on state agency activities. We're not
12 providing operational recommendations for specific state
13 programs. We're not advising state government on
14 implementation, which is really getting into operational
15 recommendations again, implementation of federal laws and
16 regulations, pursuit of federal grants, again seeing that as
17 operational. And we don't take positions on specific federal
18 or state appropriation decisions and legislation.

19 And Allen, just to give you an example, to go back to the
20 question you had asked earlier, we currently have a
21 recommendation from our first year that supports the need for
22 the state to develop a state -- a loan repayment and financial
23 incentive program for recruitment and retention of health care
24 workers. There is a bill pending in the Legislature that
25 would implement that recommendation. The Commission doesn't

1 go to -- and I don't, on behalf of the Commission, go and
2 testify at legislative hearings on behalf of that particular
3 bill. We don't write policy positions that are official
4 Position Statements. On that particular bill, as an example,
5 there actually are several related to that. So we wouldn't do
6 an analysis, identify which bill we think would work well and
7 which wouldn't and advocate on behalf of it. If asked the
8 question, does the Commission support creation of a state loan
9 repayment program for -- the other one we have currently on
10 the books is support for primary care residency program
11 development. Again it's a workforce issue, and we include
12 psychiatrists in our definition of primary care physicians and
13 specify the need to support a psychiatric residency program in
14 the state. So those are current recommendations of ours, but
15 we've made that separate from any specific advocacy work in
16 support of a particular appropriation or a particular piece of
17 legislation. Does that distinction make sense?

18 UNIDENTIFIED MALE: (Indiscernible - away from mic)

19 COMMISSIONER ERICKSON: You have a bill you want to
20 introduce? Dave and then Noah?

21 COMMISSIONER MORGAN: But take the organization I work
22 with a lot, the Primary Care Association, there is nothing to
23 preclude me or to stop me from going to the Legislature and
24 testifying for it, if our Board of Directors wants to, but I
25 never say I'm representing the Commission. We all belong to

1 different associations, statewide organizations, and we can go
2 talk to the Legislature, if we get on the list.

3 COMMISSIONER ERICKSON: On behalf of your own
4 organizations.....

5 COMMISSIONER MORGAN: Right.

6 COMMISSIONER ERICKSON:but there is absolutely
7 nothing from keeping you, at the same time, from saying this
8 is -- you know, that Health Care Commission, all they care is
9 about is money and cost, and they actually are saying the
10 state should invest, and there's a recommendation about this
11 particular issue. There is no reason why you couldn't use the
12 Commission, but just you shouldn't be testifying on behalf of
13 the Commission in support of a particular piece of legislation
14 or a particular appropriation.

15 COMMISSIONER LAUFER: I suspect this is politically
16 naive, but is this a little bit of an endorsement that, at
17 least, somebody thinks that we're actually maybe going to come
18 up with something or do something? I mean, it sounds like,
19 geesh, don't overstate your importance. Is that -- am I
20 misinterpreting that? But that's kind of nice to hear that
21 we're not supposed to say anything.

22 COMMISSIONER ERICKSON: Moving right along, this is --
23 Noah referred to that State of Reform conference that happened
24 ten days ago. It actually inspired this slide. For folks who
25 are online who might be following along, I'm on slide ten.

1 Particularly the efforts to make sure that we understand the
2 current problems in the system, but any of the work we're
3 doing here is not about blaming hospitals. It's not about
4 blaming physicians. It's not about blaming individuals and
5 patients. It's not about blaming insurers. It's not about
6 blaming the government. I felt as though -- I guess I felt
7 like I had to do that. There's lots of finger-pointing.
8 Nobody is pointing back at themselves. There was a lot of
9 that at that meeting. I appreciated one of the commenters at
10 the very end who responded -- made the comment that we all
11 need to stop blaming each other and start working together on
12 solutions and that's really what all of this is about. To the
13 extent that any of the digging into the particular issues
14 feels uncomfortable to the folks being in the sectors we're
15 looking into, it really isn't what we're about. We're not
16 trying to find somebody to blame. We're trying to make sure
17 we understand the problem well enough, so that we have
18 sufficient information to make sure we're coming up with
19 meaningful and effective strategies, solutions.

20 So I think what I am going to suggest -- it's kind of
21 hard to do this in the afternoon, and before we start digging
22 into some of the Findings and Recommendation statements that
23 we already have drafted, which, hopefully, will be relatively
24 easy to get through -- we'll see how that goes, but what I'd
25 like to do actually is take a little bit of time while it's

1 fresh, but just to brainstorm so it's easy, so we're not
2 feeling like we're having to craft something right now, and
3 start with the first presentation we had today. All of you
4 had good questions and good thoughts this morning when you
5 initially heard that presentation, understanding that that
6 report -- I mean, we don't have the report. The presentation
7 this morning was the first time you were hearing it, but if
8 you all want to take a few minutes to reflect on -- now that
9 you've had a little bit of time to digest it, do a little
10 brainstorming on what you think the significant takeaways at
11 this point are related to what we've been learning about
12 reimbursement and cost drivers for hospitals and health care.

13 What I want to do is spend a little time just
14 brainstorming, like we did at the end of the last meeting, and
15 capturing some thoughts while they're fresh. And what I'd
16 like to do is maybe pull those together and synthesize them
17 tonight to bring back to you tomorrow and then we'll spend a
18 little time starting to dig into some of our draft statements
19 that are already compiled.

20 COMMISSIONER FRIEDRICHS: If I may, if this is helpful,
21 at the end, just to try and understand in my own mind, I tried
22 to capture the main points that they had articulated in their
23 presentation, and what I took away was that there were five
24 attributes to the higher cost of health care in Alaska.
25 Medical salaries was one attribute. Those were 2% to 10%

1 higher than in the comparison states -- which were to 2% to
2 10% higher than in comparison states. Then the second
3 attribute was that the cost of living in Alaska is 15% to 20%
4 higher than in comparison states. The third attribute was low
5 physician discounts. The fourth was inefficient rural
6 hospitals. And then the fifth was high urban hospitals
7 margins, and they caveated that by saying that there were
8 really two hospitals in particular. And this was that whole
9 discussion about it's not that every hospital in Alaska has
10 high margins, but there were two of the four that they were
11 looking at. And so that's what I had jotted down, at least as
12 a starting point for discussion after.

13 CHAIR HURLBURT: Paul, on your first point, thinking of
14 an audience reading this, not benefitting by the discussion,
15 when we say medical salaries are higher, I think you're
16 probably excluding provider compensation there. They did not
17 -- they said they didn't have the data on the provider
18 compensation. So it's non-provider medical.

19 COMMISSIONER FRIEDRICHS: Because they had nurse
20 practitioners and physicians assistants, so I think you're
21 right. It's physicians, and I'll look back while others are
22 talking and just confirm.

23 COMMISSIONER HIPPLER: On slide 41, they talk about
24 physician and surgeon compensation being 110% of the
25 comparison states.

1 COMMISSIONER ERICKSON: Was that employed? That wasn't
2 capturing, I don't think, the compensation level packages for
3 them.

4 COMMISSIONER BRANCO: Can I ask a friendly amendment?
5 Instead of the word inefficient, maybe less efficient, please.

6 COMMISSIONER FRIEDRICHS: I support my esteemed
7 colleague's editorial comment. I'm just quoting what I heard
8 them say, but.....

9 COMMISSIONER ERICKSON: Since we're working on that, too,
10 without -- I'm not going to take the time to go back and look
11 at the slides and my notes about it, but just to refresh my
12 memory, Alaska's rural hospitals are less efficient than the
13 aggregate of all of the comparison states, but not necessarily
14 less efficient than rural hospitals in other areas, the rural
15 hospitals in the comparison states. Is that a correct
16 statement?

17 COMMISSIONER BRANCO: That's the way I understood it, but
18 I didn't want to make a long sentence.

19 COMMISSIONER ERICKSON: Well, I think it's really
20 important. I think it's a really important distinction, if I
21 am understanding that correctly. Val and then Jeff?

22 COMMISSIONER DAVIDSON: So can you add this after costs
23 and before in, so it now would read, "five attributes of
24 medical costs of 64% of the hospitals surveyed in Alaska"?

25 COMMISSIONER FRIEDRICHS: Or non-federal and non-profit.

1 COMMISSIONER ERICKSON: Yeah (affirmative). I think it
2 would be way more descriptive to do what Paul suggests because
3 -- two things. I think one of the things that's significant
4 isn't the percentage of the facilities, but the percentage of
5 care provided, and if we use 64% of the facilities without
6 capturing the percentage of the actual care that was provided
7 by the hospitals included. But I think, more significantly to
8 Paul's point, is, in our 2009 report, we did, I thought, a
9 good job of describing Alaska's current health care system and
10 describing, really, the three different sectors, federal,
11 tribal, and private, and this really is looking at the
12 attributes of the private medical system. So what if we were
13 to do both, Val, but if we can get at the proportion of the
14 volume of care of those facilities? I don't know if we can
15 get at that. Jeff's shaking his head.

16 COMMISSIONER DAVIDSON: Well, I think three of the
17 largest hospitals in Alaska were excluded from that study,
18 right? So ANMC was not included.

19 COMMISSIONER ERICKSON: ANMC, Elmendorf.....

20 COMMISSIONER DAVIDSON: The VA hospital wasn't included
21 and then Fairbanks.

22 COMMISSIONER ERICKSON: I don't that the.....

23 COMMISSIONER DAVIDSON: Or is it just two?

24 COMMISSIONER ERICKSON: It's just two, I think.

25 COMMISSIONER FRIEDRICHS: I would agree. I think it's

1 two.

2 COMMISSIONER ERICKSON: Elmendorf/VA.

3 COMMISSIONER FRIEDRICH: Correct.

4 COMMISSIONER ERICKSON: And ANMC, Alaska Native Medical
5 Center.

6 COMMISSIONER FRIEDRICH: Yeah (affirmative), but you
7 know to get back to the point, and Val, I agree that we need
8 to be very clear in what we're describing. From the
9 standpoint of Medicaid, at least from the DOD/VA part, we bill
10 almost nothing to Medicaid. We contribute very little to
11 Medicaid's increasing costs along the way. So if the
12 Legislature is going to look at where they're spending money
13 for the Medicaid program, for example, whatever happens in our
14 facility is not relevant to the different situation with the
15 tribal system, and it would be interesting to look at that,
16 but I don't know that that negates the value of the analysis
17 that was done here. It's a different analysis that maybe we
18 should capture for 2012 to look into, since you and Dave both
19 said the data is available. That might be something to look
20 at for 2012.

21 COMMISSIONER DAVIS: Deb, adding onto the number four
22 that you're playing with there, just as a thought to capture,
23 I thought Pat's example of the orthopedic surgeons -- you need
24 two -- you really only need one-and-a-quarter, but you have to
25 hire two -- it's about economies of scale somehow in the

1 rural. So it's not -- when you think of inefficient, that's
2 kind of a pejorative. It is economies of scale drive higher
3 costs in these rural facilities. So maybe it's important to
4 capture that.

5 COMMISSIONER ENNIS: Another point that was noted was the
6 fact that Alaska has more nurses, more FTE nurses per occupied
7 bed and cited 25% to 30% higher on staffing ratio and that's
8 higher, both in rural and urban. So it's across. The slide
9 is number 38.

10 COMMISSIONER ERICKSON: Are you suggesting that's an
11 additional attribute or.....

12 COMMISSIONER ENNIS: Well, I think the staffing is
13 additional cost. Now you know, is that an Alaska need? I
14 don't think they went into the explanation, but it is driving
15 the cost up to have more employees than is the national
16 average, I guess, or the comparison state average.

17 COMMISSIONER FRIEDRICHS: Emily, what I jotted down on
18 that, you know when we went back and asked them to clarify on
19 that, is that they were concerned that this was due to
20 variation in regional practice patterns between the rural and
21 the urban communities, which then goes back to Pat's point
22 about the staffing required for a relatively small number of
23 beds, and if you.....

24 COMMISSIONER ENNIS: Right. They gave us a figure of --
25 but it was close -- 2.7 in Anchorage and 2.5 in rural per

1 occupied bed. So you know, that's not a big difference
2 between rural and urban, I don't think, but there is
3 definitely more in the rural.

4 COMMISSIONER DAVIS: It's just an interesting point, you
5 know, when you think about why that could be.

6 COMMISSIONER ENNIS: Yes.

7 COMMISSIONER DAVIS: I mean, tertiary care is
8 concentrated here. If you think about a market like Seattle
9 that might, perhaps, be compared to, you've got downtown that
10 looks a lot like Anchorage, but then you also have, you know,
11 the rest of the hospitals that look, you know, more like non-
12 tertiary care. And so then if you look at the nurse ratio in
13 that bigger chunk, you might end up with a lower number
14 because the proportion of tertiary care might be lower. And
15 we could come up with a lot of hypotheses, but it's
16 interesting to note, and it may be one of the reasons that our
17 costs are higher, but it's driven by something that makes
18 sense.

19 COMMISSIONER DAVIDSON: He said this really quietly and
20 sort of in passing, so I almost missed it, but can somebody
21 correct me if I'm wrong? But didn't he say also at one point
22 -- one of them also say that this information didn't include
23 Blue Cross data?

24 COMMISSIONER DAVIS: One slide did not.

25 COMMISSIONER ERICKSON: It was just one. Which one was

1 it? I'd have to go back and look. I've got it.

2 COMMISSIONER DAVIDSON: Sometimes, that just one is.....

3 COMMISSIONER DAVIS: Slide number 47.

4 COMMISSIONER ERICKSON: It was the provider discount.

5 COMMISSIONER DAVIS: 47, slide 47.

6 COMMISSIONER DAVIDSON: Thanks.

7 COMMISSIONER DAVIS: Well you know, and I'm sure it's
8 because it's not in the data set because we don't -- most
9 Blues plans don't give their numbers out to third-parties, but
10 you know, I think part of this is to just give the guys a
11 little bit of a break. You know, we asked them to do this and
12 to do it pretty quickly, and they have to use available data.
13 They can't do primary data collection for the analysis and the
14 time and money we gave them, but anyway.

15 COMMISSIONER FRIEDRICHS: I think that's a great point
16 there. Like the nursing question, as I'm thinking through
17 this, may tie into this whole issue of the traveling nurses
18 that we import into the community. You know, that was the
19 other piece of the discussion that we captured both here and
20 in the workforce briefing subsequently. Depending on the
21 specialty, 11% or 15% of the workforce are imported medical
22 staff because we lack sufficient providers here. Certainly,
23 you know, in the arena in which I work, most urologists, I
24 think, will tell you they probably don't see the same nurse in
25 the operating room twice in a month because there are so many

1 traveling nurses that come up to help with it. That's a
2 result of the workforce shortage.

3 So I don't understand the methodology, as I think through
4 Emily's excellent question in more detail, and perhaps that's
5 something that we can capture also to consider looking at for
6 2012 in more detail. I think we actually probably have the
7 answer between the workforce studies that have already been
8 done on the nursing shortages and some of the data that was
9 captured here and that's why I'm reluctant to do much with
10 that in the report because I can't synthesize the data to come
11 up with an explanation right now.

12 COMMISSIONER BRANCO: Deb, to go back to the first one,
13 you put in the parentheses "excluding physicians." I'm
14 looking at the same slide that Allen brought up, and it does
15 say 110%, and if it excludes tribal health and the VA, if
16 anything, that would bring that number down because they get
17 paid by a set governmental scale that's usually less than
18 what's in the private sector. So I would remove the part that
19 says excluding physician compensation.

20 CHAIR HURLBURT: Yeah (affirmative). That's a different
21 survey, and as I understand that survey, it would include
22 those and those are salaried physicians, not -- yeah
23 (affirmative). But no. I can't say I'm sure, but I'm pretty
24 comfortable because I've used that salary analysis in trying
25 to set salaries for nurses and others where you buy that

1 information, but that is salaried people is my understanding
2 on that. But you know, probably we should go back to them and
3 ask them to be clear. Yeah (affirmative), Allen?

4 COMMISSIONER HIPPLER: Mr. Chairman, if we're not using
5 slide 41, slide 40 basically says that our salaries are
6 virtually no different than the comparison states. For
7 example, there is no figure on the maximums that say 10% more.
8 The highest one is 109%, and you know, the average is 104%.
9 So if we're not going to use slide 41, 2% to 10% is a bit of
10 an exaggeration.

11 COMMISSIONER ERICKSON: I think the conversation is
12 specific to physicians though. Physicians are not included on
13 slide 40, and we're trying to get at the extent to which
14 physician compensation, which, if we're not looking at -- if
15 slide 41 is only capturing salaried physicians, it's not
16 capturing compensation of most of the private sector
17 physicians; is that correct? Is that what we're struggling
18 with here?

19 COMMISSIONER DAVIS: That's, I believe, the question that
20 we're struggling with. What I was going to suggest is that we
21 do as Dr. Hurlburt suggested and go back to them and clarify
22 what the source is, but if this is just salaried physicians,
23 then encourage them to find another source. The Medical Group
24 Management Association has data around this that, I think,
25 would be helpful because salaried is not, probably, the number

1 we're looking for. We're looking for people in general
2 practice, private practice.

3 CHAIR HURLBURT: Although MGMA doesn't have a lot of
4 participants up here because we don't have (indiscernible -
5 away from mic).

6 COMMISSIONER DAVIS: Yeah (affirmative). Maybe.

7 COMMISSIONER LAUFER: Didn't the stuff we saw earlier
8 where they were talking about reimbursement for billing codes
9 for subspecialties, that answers that to some degree, and you
10 know, I noticed that they kind of retracted some of that after
11 being asked to really look at it.

12 I hate to do this. I know this is 50,000 feet and
13 everything, but that's not really where the issues are and the
14 drivers are, you know. You said you don't have the same nurse
15 in the OR, you know. The bigger question would be, does the
16 nurse know what the name of the instruments are? Have they
17 ever worked with a urologist before? Are they a danger to the
18 patients? You know, those are the real big questions. Or you
19 know, it costs more at Prov. Well if somebody does a
20 colesectomy in the Valley and it goes bad, they don't keep
21 them there. They say, you know, it's more than we can handle,
22 into Prov and then that's a much longer stay in the hospital,
23 more complications. The doc who takes them is often an EMTALA
24 doc who doesn't get paid and eats it and eats the liability.
25 You know, these things aren't -- that's what matters, the

1 daily life of the docs and retaining them and that's not being
2 addressed here. You know, it's more complicated than
3 everybody thinks.

4 COMMISSIONER FRIEDRICHS: No. I agree with everything
5 that you've said. I thought that what we were trying to do
6 though was to summarize the discussion we had this morning. I
7 mean, this morning's discussion is a subset of the broader
8 discussion that we touched on a couple of times, which is the
9 linkage between cost, quality, and outcomes, ultimately.

10 We can go to the very 50,000 foot view and summarize of
11 all it by saying that the Legislature should pass laws that
12 control costs and provide high quality care as efficiently as
13 possible, and then you know, we've covered all the bases. Or
14 what I was hoping to get away from this or get into with this
15 one was providing some of the data that we've collected over
16 the year. I mean, the discussion that I've been involved in
17 at the national level is always whose ox is going to get gored
18 the most, and we have the luxury here of having some data that
19 we can put out to dispel, at least -- or not dispel, but shape
20 the discussion to say here is what we've been able to find.
21 We've spent a year paying consultants to go look at it. Based
22 on what we're able to find, physicians are not being paid
23 wildly more or nurses are not being paid wildly more. If on
24 the other hand, if we.....

25 COMMISSIONER LAUFER: The conclusion is the *Titanic* is

1 sinking. Oh, yeah (affirmative).

2 COMMISSIONER FRIEDRICH: No. I disagree. That's not
3 the conclusion at all. The conclusion, I hope, will become
4 more apparent as we capture all of the data points that we've
5 collected over the course of the year. You know, this goes
6 back to the whole discussion about whether it's long-term care
7 or workforce management or whatever else. If you have \$100
8 and you're going to spend just that \$100, you can opt to spend
9 \$50 of that on hiring one doc or you can hire 50 community
10 health aides. Which one is going to give -- which decision
11 will give you the greatest return on investment?

12 Part of what I hope we can do with all of this is to lay
13 out the data points that we've collected to inform the
14 Legislature. I mean, if they come back and they say hey, you
15 know, the solution to balancing Medicaid is let's cut
16 physicians' salaries, they would be right in step with what's
17 happening at the federal level. That has been one of the
18 primary drivers. That's the whole SGR formula that's been out
19 there for 12 years now. It has not been effective. It
20 certainly has not been able to be implemented because of all
21 the second and third order effects.

22 I mentioned to Ward at the break -- and I apologize for
23 philosophizing, but you know, Alaska has this unique
24 opportunity. Unlike any other state in the union, we don't
25 have a health care system in this state. We've talked about

1 this repeatedly. You know, the most exciting part of this
2 whole group and this whole effort is if we can help to shape
3 the building of a real sustainable health care system in
4 Alaska. Everybody else is talking about how do we undo 200
5 years of decisions that have resulted in an ineffective health
6 care system. We, on the other hand, are saying we're still
7 starting. How do we build a sustainable health care system?
8 And part of that is putting the data out there right now.
9 Where are we spending our money today? And then from that,
10 you can decide where you want to spend it in the future to
11 address quality and quality of life and all those other
12 issues.

13 COMMISSIONER DAVIS: So yeah (affirmative). I agree,
14 Paul. I think a lot of this is about putting stakes in the
15 ground and separating fact from fiction and that's what we're
16 trying to do.

17 It's not a finding, Deb, but it's just part of thinking
18 about this presentation. I think they did leave a hole that
19 needs to be filled in, and it may be because we've seen part
20 one, and now, we've seen part two. But on slide 22, there is
21 the finding that, in Alaska, Physician Reimbursement by State
22 and Payer, Commercial Allowed - Mean, 167% of the comparison
23 states and then the 80th Percentile is 174%. So they put this
24 number out there that physician reimbursement is significantly
25 higher, but then they don't finish it, you know. So maybe

1 that's in part one. Maybe that's in part three. I don't
2 know, but we need to make sure that they do come back to that
3 number. And I would also suggest that they need to come back
4 to the differentiation by specialty because, just as we talked
5 about with the hospitals, you have two that are highly
6 profitable and two that aren't. You know, it's an actuarial
7 joke that, you know, two actuaries are playing golf. One hits
8 the ball 100 yards right. One hits the ball 100 yards left.
9 On average, they both had a hole-in-one, right?

10 So we want to understand the physician piece well enough
11 that our stakes in the ground are accurate and we ask for, by
12 specialty, by CPT4 code, by region, and we need to be able to
13 see that breakout by payer breakout, as they've got on slide
14 22. So just in thinking about our discussions with them going
15 forward as what we want to see, I believe that's key to
16 understanding this.

17 CHAIR HURLBURT: You know, I think that I agree it's
18 appropriate to ask them to pursue that more because it is an
19 issue, but they won't be able to be as definitive as they can
20 with hospitals.....

21 COMMISSIONER DAVIS: Correct.

22 CHAIR HURLBURT:because the private sector
23 hospitals file the cost report and physicians don't do that,
24 and we don't want to go out and look at a physician's 1040 to
25 see what they do. So I think they can pursue it more, but it

1 will still be a little more iffy and nebulous, I think, than
2 what we can get with hospitals.

3 COMMISSIONER DAVIS: I agree and I expect that, but I
4 also expect you'll see Specialty A here and Specialty B here
5 and that that needs to be understood, so that we're not
6 tarring, if there is any tarring to be done with the same --
7 with one brush or that's that I'm getting to by specialty and
8 certainly not by physician.

9 COMMISSIONER ERICKSON: We do the -- I can't remember if
10 it's the first or second, but one of those first two reports,
11 the one that's specific to physician reimbursement, includes a
12 significant appendix of all of the data tables of the
13 comparison by specialty, by payer.

14 COMMISSIONER DAVIS: But that was not in what they
15 presented to us, and I'm thinking, in the final report, it's
16 going to be important to have that detail because, if you
17 combine commercial and Medicare and Medicaid and VA all
18 together, you get, again on average, a hole-in-one, even
19 though you were 100 yards off.

20 COMMISSIONER ERICKSON: And I don't remember if we
21 mentioned this this morning. We will receive the draft
22 narrative of the cost driver report if not Friday --
23 technically, it's due from them on Saturday. So we should
24 have it by Monday. And so we'll have a chance to review the
25 narrative and have a chance to provide some feedback, if there

1 is something that requires clarification, if we need to ask
2 them to dig into an area a little bit deeper.

3 COMMISSIONER CAMPBELL: I don't want to muddy the water,
4 but I've got a niggling, uncomfortable feeling that we may be
5 overlooking a couple of cost drivers that could be pretty
6 important. The cost of drugs just comes to mind. I'll think
7 of two or three more, and I'll call you at two in the morning
8 when I think of them, Ward. But I think that we're not
9 getting at the full picture of the cost drivers.

10 CHAIR HURLBURT: Right, and we had talked earlier about
11 getting the pharmaceutical costs, about getting the acute long
12 -- or the long-term care costs, like SNF, skilled level long-
13 term care costs, and looking at those. They were not in the
14 initial RFP, and maybe Deb, you could say (indiscernible -
15 simultaneous speaking).

16 COMMISSIONER ERICKSON: We had actually talked about that
17 before, and we have -- I have approval now to release an RFP
18 to study these two areas.

19 COMMISSIONER FRIEDRICHS: My memory may be playing tricks
20 on me, but I thought that we had an excellent presentation
21 from the Medicaid Task Force that looked at pharmaceutical
22 costs within the year and they laid out the -- you know, the
23 \$26 million of savings that they were recommending out of the
24 \$500 million program, but we did look at that about a year or
25 so ago.

1 CHAIR HURLBURT: That was specific to Medicaid.

2 COMMISSIONER FRIEDRICHS: Right.

3 CHAIR HURLBURT: And there were some things, like their
4 purchasing, where it was AWP minus five that they were doing,
5 and they're looking at changing that. They're tightening up
6 on the preferred drug list, so it takes more than just a
7 signature by a provider to override that, but that's just
8 Medicaid, and I think the rest of it we're looking at
9 commercial business, looking at the whole sector and that we
10 don't have. Yeah (affirmative).

11 COMMISSIONER DAVIDSON: So one thing I kept waiting for
12 them to say, and maybe it's because of the group that was
13 excluded, was freight. I mean, in terms -- is freight just a
14 buried cost? Is it a.....

15 COMMISSIONER ERICKSON: I believe it's part of the
16 operating costs, which they did capture.

17 COMMISSIONER DAVIDSON: But it's a significant part of
18 that driver.

19 COMMISSIONER LAUFER: A lot of our labs we typically get
20 through Quest, and a huge majority of those go to Seattle to
21 be processed. Those are flights in and out of town. I mean,
22 even in Anchorage, it's a huge deal. I like your question a
23 couple visits ago, what do you have to pay the snowplow guy to
24 plow the parking lot if milk is \$10 a gallon, and you know, I
25 mean, it's just not comparable. And whether -- you know, that

1 cost translates into Anchorage as well. It's shared.

2 COMMISSIONER BRANCO: Just very quickly, just to
3 piggyback on that, I raised that issue of one of the cost
4 drivers being logistics, all forms of logistics. About a half
5 to three-quarters are captured in my cost report. The rest
6 are these intangibles, and again because they're intangible,
7 they'll never end up in the document, like this, that we can
8 quantify and make decisions around, but they are there. The
9 cost of temporary staffing, it doesn't show up on my -- other
10 than a labor cost, it doesn't reflect the low productivity or
11 what we call the temporary attitude that really don't care as
12 much about -- well, it's a fact, but it's not on my cost
13 report. So there is a -- I have a whole list of the other
14 costs that I'm accountable to that don't their way to the cost
15 report.

16 COMMISSIONER HIPPLER: Thank you, Mr. Chairman.
17 Sometimes I think of freight as part of cost of living,
18 although I understand it's important and different. There's
19 something that wasn't in the Milliman report that the Alaska
20 State Hospital and Nursing Association was so kind to tell us.

21 Uncompensated care, relative to the rest of the United
22 States, is 75% higher, 75% higher. It's 21% versus 12%. It's
23 a lot.

24 COMMISSIONER LAUFER: Just in private practice, that's
25 important, and part of that is the nature of people's

1 employment. It's off and on. They're insured and uninsured.
2 You know, we're long-term. We're used to, you know, trying to
3 collect. It's 120 days, and you've sent everything and
4 called. You don't hear anything, but that's because they're
5 at Saint Lawrence Island or somewhere. And so it is; it's a
6 different environment, and I do consciously, even in a small
7 business practice, give away a lot of care because it's a lost
8 leader to the community because I know they have aunts and
9 uncles, and you know, cousins and everybody is talking to each
10 other, and it's just part of the deal, but at the end of the
11 month, I've got to pay my mortgage. And so we just bill Jeff
12 more.

13 CHAIR HURLBURT: Pat, could I ask a question on how you
14 define uncompensated care? Is uncompensated care the care for
15 which there is no reimbursement? Is it the delta between the
16 cost of care and what you get or is it the difference between
17 what your established billed charge would be and what you
18 receive, which may be nothing or may be Medicaid, which is
19 less than your billed level of charges?

20 COMMISSIONER BRANCO: In the ten-second answer, it is a
21 combination of all of that. It's divided into the two
22 categories, bad debt, those amounts that we get no answer
23 from, and the other portion is in charity care. And in any
24 given year, a tough economy, the bad debt rises, so that
25 portion, billed charges and then reimbursed. Outside of

1 insurers, this is the private portion of that bill, and
2 charity care is those that are arranged to have some support,
3 discount, or portion of their care covered by us.

4 COMMISSIONER KELLER: As a charity care, that has tax
5 implications, but is that much different than the others?

6 COMMISSIONER BRANCO: This is really -- I'm sorry?

7 UNIDENTIFIED FEMALE: (Indiscernible - away from mic)

8 COMMISSIONER KELLER: Oh, I'm sorry. Do you got the
9 question?

10 COMMISSIONER BRANCO: I got the question. I have the
11 answer, and this is a significant part of being in Alaska,
12 too. The folks in -- this goes to tax exempt status for a
13 large number of not-for-profit hospitals. Typically in the
14 rest of the country, and I'm not speaking from a data point
15 that, if I get it off by a tenth of a percent I want anybody
16 to come back and attribute to me, but typically across the
17 country, in order to maintain tax exempt status, you have to
18 produce about 2% of charitable care. So it keeps your doors
19 open, but there is always a neighboring hospital that you can
20 shift some folks over to, to balance that out so you're not
21 unnecessarily or disproportionately shared with the rest of
22 the country. Typically in Alaska, we're providing charity
23 care at 6%-8%. It's a huge factor, and it really is because
24 of rurality of our state and the fact that we're taking care
25 of people in our communities.

1 COMMISSIONER LAUFER: It's not just charity care to
2 people who are poor; it's to everybody. You know, you're
3 going out on your boat. You call me. You want some
4 Scopolamine patches. I'm making a medical decision, taking a
5 risk, and I say, you know, sure. Of course, I'll call it in.
6 I'm going to Arizona. I want to do this. My kids that. You
7 know, I'm uninsured. I'm self-pay. Can you down code me,
8 which we down code all the time. It's you know, systemic.
9 Every time there is an audit of primary care physician coding,
10 it's under-coded, under-billed. It's sort of -- it's endless,
11 I mean.

12 There was an article in the *New York Times* this year,
13 primary care physicians are compensated for one-fifth of the
14 work that we do. Yeah (affirmative), and a lot of it's stuff
15 you wouldn't think, you know. I need this letter for
16 refilling a proton pump inhibitor for a patient from the
17 pharmacy benefits management company that the insurer has
18 hired to lower their cost. Then I've got to fill it out, and
19 you know, the only way to get compensated is to call the
20 patient and say look, I need you to come in and have a visit,
21 and you know, we'll discuss this and then I'll bill it and
22 that's not honest. And so we typically don't do it, but it's
23 endless.

24 COMMISSIONER BRANCO: There is one more piece to this,
25 and I was new to it when we began employing physicians because

1 they would ask -- they would make deals with their patients.
2 Don't worry about it. I'm not going to write this out. I'm
3 not to record the visit. I'm not going to have you pay for
4 anything. I'm just going to do it.

5 Part of this is covered by the cost report, too, so what
6 we had to encourage the docs to do was please document the
7 care and then ask for the forgiveness of the bill. We can do
8 it in a charity form, but it's inappropriate, and again if you
9 get caught, there are penalties and fines associated with
10 that, but it is account for the care, deliver the care,
11 document the care, and then we'll discount it or eliminate the
12 charge, but you have to do it in that order. It's hard.

13 COMMISSIONER LAUFER: Let me just underline. Just think
14 of all the efficiency that will come to our world if we all
15 have to do this all the time for a huge entity, you know. I
16 mean, if we're only documenting and being compensated for a
17 fifth of what we do and now we have to document five times as
18 much to provide the same care, oh yeah (affirmative), there is
19 going to be a lot of efficiency there. We'll all quit, too.

20 CHAIR HURLBURT: To what extent can an electronic medical
21 record just incorporate that and take it from your note, your
22 visit note?

23 COMMISSIONER LAUFER: So the ideal electronic medical
24 record system or the existing electronic medical record
25 system, because it's very hard to capture everything that

1 happens in a primary care visit because there are typically
2 eight or more things going on. We try to do that. You've got
3 to code all of them, and shortly now, we have to provide a
4 written summary to each patient of what we did in addition to
5 the note, and I'll tell you that's one of the things that's
6 greatly detracting from my enjoyment of my job is that I'm
7 spending more and more time looking at the screen and typing
8 and less and less talking to patients. Theoretically, it
9 could, and these things do get documented, like telephone
10 things, but right now, there is no way for me to bill, you
11 know, easily for the Scopolamine patches for someone who is
12 going out on the water, or you know, a lot of the stuff that
13 we do that's, frankly, easier for me just to -- you know, a
14 quick touch. I know them. Call me if this doesn't work and
15 done, but you know, the documenting is a big burden also, and
16 we have to pay people to do it.

17 CHAIR HURLBURT: And yet, you have to document for
18 medical legal reasons.

19 COMMISSIONER LAUFER: Absolutely.

20 CHAIR HURLBURT: If you document, the courts will give
21 you the benefit of the doubt. If you don't document, it
22 didn't happen, even if it did.

23 COMMISSIONER LAUFER: Right. So I've said this before,
24 but this medical record system that started out as a note to
25 me that I saw somebody for pneumonia on this date is becoming

1 this hugely complex tool of different entities, and you know,
2 do we just have a running video/audio record of what's
3 happening in my office? You know, I mean, it's -- you know,
4 it would be helpful for the Commission to go follow some docs
5 around.

6 COMMISSIONER DAVIDSON: There is one circle with a line
7 drawn through that we forgot because we always like to talk
8 about tort reform. So I think we should also add one that
9 says blaming lawyers. You want to talk about -- okay. I'm
10 just saying.

11 COMMISSIONER ERICKSON: We intentionally left that one
12 out.

13 COMMISSIONER MORGAN: At the Affordability Conference,
14 were you in the one -- everyone will love this. Was it Dr.
15 Etzel (ph)? He was on your panel. Kiesel (ph)? Kiessling.
16 He said anybody that wasn't a doctor involved in this was a
17 parasite. That's the first time I've been called a parasite.
18 I said -- well, I told him I'd rather be a newt instead of a
19 parasite. He didn't think it was funny.

20 COMMISSIONER ERICKSON: He's the radio talk show
21 host/physician. He was a singer. He had a very nice voice
22 when he sang "Unsustainable" to all the providers in the room
23 to the tune of "Unforgettable."

24 COMMISSIONER MORGAN: Wasn't he also -- some rockstar
25 came to town or something and he became his doctor?

1 COMMISSIONER ERICKSON: Elton John.

2 COMMISSIONER MORGAN: Elton John.

3 COMMISSIONER ERICKSON: He took care of Elton John.

4 COMMISSIONER MORGAN: I'll bet you he's got
5 (indiscernible - voice lowered).

6 COMMISSIONER ERICKSON: So I want to go back to the
7 uncompensated care because that reminded me of something else,
8 and I'm trying to understand the unpaid billed charges and I
9 don't know enough about the business to probably fairly
10 characterize this, but the way I understand billed charges is
11 it's the price that you really don't ever get, right? So I
12 got a thumbs-up. So I don't understand what the significance
13 of comparing.....

14 COMMISSIONER BRANCO: Me either.

15 COMMISSIONER ERICKSON:uncompensated -- thank you.
16 You answered my question now, but I think what I want to get
17 at is one of the huge takeaways from me -- well one, I thought
18 it was significant that they, essentially, ruled out one-half
19 of the equation, price versus utilization. As our overall
20 cost picture, utilization isn't what is driving it.

21 So that was one piece that I thought was important to
22 know, but the other piece was the cost-shifting, and it really
23 struck me when they had the hospital margins slide up where
24 they thought it would be interesting for the group just to see
25 the Medicare operating margins. And so what that slide was

1 telling us, I believe, is that commercial payers are
2 subsidizing certainly Medicare. Medicaid is closer to the
3 line; is that right? So to a small extent, maybe Medicaid.
4 To a great extent, the Medicare population. So the public
5 payers are being subsidized by -- not by Jeff, but by the
6 businesses -- the employers and the individuals who buy
7 insurance from Jeff; is that correct?

8 COMMISSIONER BRANCO: That's correct.

9 COMMISSIONER ERICKSON: And then so to the extent that
10 our Medicare population is growing and we're faced with a
11 possibility, if not probability, that Medicare rates are
12 potentially going to be squeezed within the debt discussions,
13 how much more can the commercially insured population pick up
14 the bill for the rest of the populations?

15 COMMISSIONER BRANCO: That's a true unknown, but.....

16 CHAIR HURLBURT: Yeah (affirmative). I think an
17 important factor on utilization is the conclusion. The
18 information they showed us and the conclusion we can draw is
19 that utilization is not driving our cost to be higher than the
20 comparative states. It is -- I do not think we can draw the
21 conclusion that the utilization is appropriate. As Noah
22 pointed out in the health policy meeting, when he has his
23 heart attack, he doesn't want to go to the hospital and have
24 hope, but he also, when he has chronic stable angina, he
25 doesn't want to go and have somebody put a stent in, like a

1 third of all stents are. So the information we have is that
2 we're no better; we're no worse, but they're probably are
3 areas in terms of evidence-based quality care where the whole
4 country can do better, including Alaska.

5 COMMISSIONER MORGAN: Yeah (affirmative). What I have
6 found is that there are -- overall, their statement is a true
7 statement, but if you segment different groups, whether it's
8 Blue Cross or Medicaid, there is 10% or 15% that are the
9 outliers that are using -- that are chronic and using a whole
10 lot of the resources. That doesn't mean -- but that's a true
11 statement probably in any system or any state, and the patient
12 medical home -- the medical home and some of the other chronic
13 care management, case management is to bring them back into
14 the -- outside of the outlier. So I agree. If you segment
15 and look at certain populations, we do have high utilizers for
16 some reason, not necessarily a bad reason, but a reason. And
17 for that population, it's driving some costs. But overall,
18 the way I got it was I agree with you that we're no better, no
19 worse than any other state in the aggregate.

20 COMMISSIONER DAVIDSON: I'm not sure where that last
21 bullet came from, and I would really disagree with that
22 statement. I think that the truth is that costs are shifted
23 among payers, public and private. As one shifts, the other
24 shifts. I mean, it's all -- I mean, you could say the same
25 thing about the fact that Medicaid provides sufficient

1 reimbursement in this state through federal funds and state
2 funds that provides a base level of health care that makes it
3 affordable for everybody else. I mean, it cuts both ways. So
4 I'm not really comfortable with -- I would really object to
5 something that said that commercially insured subsidizes
6 publicly covered populations. I think it goes both ways.

7 CHAIR HURLBURT: I don't understand that. If you're
8 looking at the cost per unit of service as to what's paid,
9 it's uniformly true anywhere in the country, including here,
10 that the unit of service cost paid by the self-pay or by the
11 private insurance is significantly higher than Medicare or
12 Medicaid, for example.

13 COMMISSIONER DAVIDSON: I guess I'm thinking of in terms
14 of the area that I'm most familiar with. Let's say rural
15 Alaska, where Medicaid is typically the bigger payer, but
16 Medicaid -- if there weren't a base program of a tribal health
17 system that was available, publicly-funded, federal funds,
18 some private funds, what would that do to the cost of somebody
19 who lived in Bethel, who didn't have a tribal health system,
20 who had to get care somewhere that wasn't available in Bethel?

21 I think the costs go -- I'm not articulating it very
22 carefully. Maybe one of my friends from the audience can help
23 me out here, but I think -- I mean, it is, to some degree, a
24 balloon, and as one thing gets squeezed, the other gets
25 expanded, and I think it cuts both ways. I mean, when we're

1 talking about Medicaid, we often talk about the costs of
2 Medicaid, the costs of this, the costs of that. We don't ever
3 talk about the other part of it, which is the benefit that it
4 also provides to the rest of the population. So for example,
5 the fact that Medicaid pays for immunizations, well, what does
6 that do for the cost of -- or the savings and cost to that
7 commercial population as that child who doesn't have measles
8 or mumps or pick any disease, becomes a working adult, and
9 then that person who has that job doesn't have that pre-
10 existing medical condition that drives the cost of that
11 premium up? So it cuts both ways.

12 CHAIR HURLBURT: So you're.....

13 COMMISSIONER DAVIDSON: I'm not articulating it very
14 well, but you get my point.

15 CHAIR HURLBURT: But to put in maybe business terms, your
16 thesis would be that Medicare and Medicaid cover a large part
17 of the fixed costs to have a facility in Bethel or Aniak or
18 somewhere, and if those costs weren't fixed, the total costs,
19 fixed and marginal, to enable the portion of the citizens of
20 Bethel that have Premera, for example, those total costs to
21 provide care there would just be outrageously higher than they
22 are now; is that a fair way to rephrase what you're saying?

23 COMMISSIONER DAVIDSON: Yes, and I think that same -- I
24 think that's true, and I think that same issue holds true in
25 other parts of the state and in other parts of the country,

1 beyond just rural.

2 COMMISSIONER LAUFER: The way that I think of this -- and
3 you know, my conspiratorial thinking of being up late at night
4 with no one to bounce ideas off, but basically, you know, the
5 function of Medicare and Medicaid, to some degree, is to get
6 the sick people off the rolls of the private insurance
7 industry. So if you're a bad bet, if you're uninsurable
8 because you're sick or disabled, or you know, too old, that
9 cost has been externalized to the taxpayer. That's the
10 function of it. You're too old for us to take a bet on you
11 and that would work, except that those people -- and the
12 uninsured, they still go to the ER. So the fundamental
13 problem flaw is you can't be refused by an ER. So they end up
14 at the ER. The hospital sees the cost. The doctor sees the
15 cost. The system sees the cost, and we pass it right back to
16 the insurer. So everything affects everything else. Val is
17 absolutely right, and we benefit from it.

18 CHAIR HURLBURT: But aren't 75% of the Medicaid enrollees
19 women and children who are relatively low-cost people?

20 COMMISSIONER LAUFER: Right.

21 CHAIR HURLBURT: The other 25% are the real high-cost.

22 COMMISSIONER LAUFER: Yes.

23 CHAIR HURLBURT: But most of the enrollees are healthy
24 young people.

25 COMMISSIONER LAUFER: But I think what she's saying is

1 that goes in both directions, and I think she's absolutely
2 right. One way or another, we're all in it together. We're
3 all, you know, one family, and we've got to pay for it, if
4 that's what we want. And you know, the friction is from the
5 chaffing of who is responsible and who isn't, and we're
6 running out of federal dollars, so you know. But you're
7 right; it's all shifting of it all around. Yeah
8 (affirmative).

9 COMMISSIONER DAVIS: Interesting discussion. Val, thanks
10 for that perspective. That was good. But I think, in this
11 particular study, we were trying to explain what we're seeing
12 the commercial payers are having to pay, and so to that point,
13 I think the cost shift, at least in that circumstance, is an
14 important piece of this that we need to capture. So that's
15 one point.

16 There was another point here. Sorry. Lost it.
17 Listening to this fascinating discussion, I lost it. So let's
18 leave it at that. I think we do need to capture cost shift.
19 I'm not sure how. Maybe it is that different payers are
20 paying different amounts and providers are having to balance,
21 based on that.

22 The other thing I would note as part of that is there was
23 this statement and assumption that no one pays billed charges
24 and that, in fact, is not true, at least in my experience in
25 this state. If you're a sole community hospital, you are not,

1 at least as far as I know, cutting discount contracts with
2 commercial payers. So those commercial payers are paying your
3 charges. Therefore if there are others who are not paying
4 your charges, then there is, inherently, a higher cost to the
5 commercial payer, and the same is true, in most circumstances,
6 for physicians. So I don't want us to have that assumption
7 built in that no one is paying charges. In other markets,
8 that's relatively true, but there is only one competitive
9 market in this state and that's Anchorage. So if it's not
10 competitive, then providers are price setters, not price
11 takers.

12 COMMISSIONER BRANCO: Yeah (affirmative). That's a
13 really correct point. The lack of managed care throughout
14 much of the state really does have a limiting effect on cost-
15 shifting, but there's still -- and so I'm reminded -- and if
16 you'll allow me a light moment, I'm reminded of Paul Harvey
17 who described cost-shifting in terms of the grocery store. He
18 said five identical grocery carts full of groceries. They're
19 all in line at the cashier. The first person goes through,
20 and they're told \$450. You have to pay cash. The second one
21 goes through the line, same groceries, rings it up. It's
22 \$450; however, you have grocery insurance. It's covered. Go
23 on through. The third person goes through and says I have
24 \$450, but I'm government, and therefore, just slide through.
25 You don't have any cash out-of-pocket. The fourth says I've

1 got \$450 worth of groceries here, but the guy behind me is
2 going to cover it, and he heads out. And the last guy in line
3 picks up the bulk of the charges. Thank you. And the rest of
4 the story.

5 COMMISSIONER ERICKSON: I think we're done with
6 brainstorming about cost. Keith has something more to say
7 about cost.

8 COMMISSIONER CAMPBELL: It just struck me. I'm trying to
9 remember back. Have we discussed the cost of regulation or
10 over-regulation?

11 COMMISSIONER ERICKSON: I think Noah was getting at that
12 when he was talking about the cost associated with
13 documentation and compliance.

14 COMMISSIONER CAMPBELL: Well, I missed the word
15 compliance. Sorry.

16 COMMISSIONER BRANCO: But it also -- I'm sorry. It also
17 flows into Emily's other comments about licensure and
18 background checks and pick your regulation list. It's
19 significant cost effect.

20 COMMISSIONER HIPPLER: Are these -- is this over-
21 regulation specific to the state of Alaska? I thought we were
22 talking about differences between our state and other states.
23 I would be thrilled if we could identify a regulation that was
24 specific to the state of Alaska that was a source of excess
25 costs because that would be an excellent thing to identify.

1 COMMISSIONER LAUFER: This is tiny, but I did mention
2 already to Commissioner Streur, I have a lot of, you know,
3 patients who are on Medicaid who are disabled, and every six
4 months, you get this form that has to be filled out, and you
5 can't just fill it out. You have to initial all the boxes,
6 and it says that this patient is likely to continue in this
7 state. And you know, these are people with, you know,
8 congenital abnormalities and developmental delays. They don't
9 get better. They never get better. I mean, you know, they
10 live their lives, often happy lives, but their conditions
11 don't go away, and I really tire of filling those forms out.

12 UNIDENTIFIED MALE: Is it the state of Alaska?

13 COMMISSIONER LAUFER: State of Alaska. One form.

14 CHAIR HURLBURT: Is it a federal requirement or is it a
15 state requirement? Because the Feds often view the states as
16 not being diligent enough to make sure that people qualify for
17 Medicaid, and there is often some tension where the Feds are
18 trying to be tighter and the states are wanting to be a little
19 more liberal, and there is some wiggle room in there, but it
20 is a federally controlled program.

21 COMMISSIONER LAUFER: I'll bet it's federal then.

22 CHAIR HURLBURT: Yeah (affirmative).

23 COMMISSIONER LAUFER: God.

24 CHAIR HURLBURT: Val?

25 COMMISSIONER DAVIDSON: I would recommend that you delete

1 the word over before regulation, unless you're going to add
2 over to those other categories, because one person's
3 regulation and another person's over-regulation -- you could
4 say the same thing with costs associated with over-
5 documentation and over-compliance, costs associated with over-
6 licensure and over-background checks. Who is going to make
7 that call?

8 CHAIR HURLBURT: And probably all of the regulations were
9 well-intended by somebody, but you don't always know what the
10 consequences are. It's not evil people doing devious things.
11 They think they're going a good thing and then you learn,
12 sometimes, the side effects are more costly.

13 COMMISSIONER KELLER: On your circles, you need to put
14 the word state in there where it says blaming government,
15 blaming state government. So the Feds are okay.

16 COMMISSIONER ERICKSON: I need to check in with the group
17 to see how you're feeling. We have a couple of choices, I
18 think. We could just focus on the rest of our brainstorming
19 and working on our Finding and Recommendation statements when
20 we're fresh tomorrow and wrap up right now, even though we're
21 a half-hour ahead of schedule, and focus on federal reform and
22 the Affordable Care Act.

23 I see that Commissioner Streur has joined us. We could
24 use actually, potentially, more of some of the time that we've
25 saved here for that. Commissioner Streur actually asked me to

1 go over, quickly, the presentation that I prepared for you
2 that I hadn't been planning on presenting actually during this
3 meeting, but I could do that and then invite the Commissioner
4 up to answer questions and provide some comments. I see a
5 thumbs-up. I see heads nodding. Do you feel as though you
6 need a short break before we carry on or should we push
7 through? Let's push through.

8 CHAIR HURLBURT: Let's go ahead; yeah (affirmative).

9 COMMISSIONER ERICKSON: It's going to take me two seconds
10 here. I better hit the save button because you guys had lots
11 of good thoughts, before I lose that. I will pull up this
12 other presentation now.

13 So this presentation is posted on the Commission's
14 website on the October 2011 meeting page. It's the Overview
15 of Federal Reform. This was not included as a printout
16 handout in the back of the room this morning, but I did put it
17 back there about an hour or two ago. So for audience members
18 who are in the room, there is a printout of this presentation
19 now in the back of the room. And for Commission members, it
20 is behind tab six in your notebooks. Commissioner Streur, do
21 you want to come up and join us at the table?

22 (Pause)

23 COMMISSIONER ERICKSON: Commissioner, do you have
24 anything you want to share or say before we get started or do
25 you want me to just dive in?

1 COMMISSIONER STREUR: I think you can just dive in, Deb.

2 COMMISSIONER ERICKSON: I'm going to try to go relatively
3 quickly through this and maybe focus on some of the updates
4 specific to Alaska, with the caveat that this presentation
5 normally would take half-an-hour to 45 minutes to give, and it
6 might be hard for me. Ward, you might have to kick me under
7 the table, if I go on too long about something.

8 This is a presentation that I actually blame
9 Representative Keller for because he -- no blaming. I didn't
10 -- there wasn't anything about not blaming legislators on that
11 slide either.

12 COMMISSIONER KELLER: (Indiscernible - away from mic)

13 COMMISSIONER ERICKSON: In the long run, it's been
14 helpful for me, too, but he dragged me to Juneau a week after
15 the Affordable Care Act passed and had me give a presentation.
16 I spent the whole weekend reading the 2,000-page bill and
17 trying to synthesize it into some sort of overview, and I've
18 built on that presentation over the past, what, year-and-a-
19 half now and refined it, but I've tried to make it, one, as
20 objective as possible, not judging, one way or the other, this
21 is a good thing or a bad thing. This is just what's in it.
22 And I tried to synthesize it in a way that's more --
23 hopefully, more or less, understandable to more of a lay
24 audience. And one of the things I added to it at one point up
25 front -- because there were lots of questions about the legal

1 challenges and also the political realities of the
2 implementation of this bill, and I assume you all know that
3 Alaska is one of 26 states that's involved in a lawsuit
4 against the federal government over just simplifying this --
5 and Val, you can kick me under the table, if you can reach, if
6 I'm going too far into trying to practice law without a
7 license, but basically, the states are challenging the
8 constitutionality of the individual mandate, the requirement
9 that individuals purchase health insurance, and also the
10 unfunded mandate imposed on state governments associated with
11 the Medicaid expansion. There are questions related to
12 whether the -- if the courts were to throw those two
13 provisions out and agree with the states and some of the
14 others bringing lawsuits on one or the other of those points,
15 whether it would invalidate the entire law or not.

16 At this point, it's been moving -- that lawsuit and a
17 number of other lawsuits against the bill have been moving
18 through the courts in different parts of the country. One of
19 the appellate courts has ruled in favor of the law,
20 essentially upholding the federal law. One ruled against the
21 individual mandate and agreed with us. That was the state
22 lawsuit, actually, in the Eleventh Circuit, but upheld the
23 Medicaid expansion as an optional program that states don't
24 have to participate in.

25 One of the appellate courts actually avoided ruling on

1 the merits of the case at all and set it aside on some
2 jurisdictional grounds. And so the bottom line, right now, is
3 it's sitting with the Supreme Court, and they will be making a
4 decision sometime this fall regarding whether they're going to
5 hear this case this year on their calendar this year or not.
6 If they do, we could expect to have a ruling from them
7 sometime in June or July. I'm going to skip over some of
8 these things.

9 One of the things that I'd like to mention I used
10 Minnesota and Wisconsin as examples because both of those have
11 taken strong positions in terms of their state government's
12 position on this bill and they've flip-flopped a couple of
13 times, at least, over the past year-and-a-half. The state
14 government -- you'll hear pundits and folks from the public
15 who don't necessarily understand the state government's role
16 in implementing the law. The states really don't decide
17 whether the law gets implemented or not, but have significant
18 say in how the law will be implemented in their states.

19 And just for a couple of examples, Wisconsin, when the
20 law was passed, had a governor who was a Democrat and created
21 a whole new agency to focus on implementation of the law. In
22 Minnesota, the governor at the time, Governor Pawlenty, was a
23 Republican and actually issued an Executive Order prohibiting
24 state agencies from participating in implementation of the
25 law. And in the elections that next fall, then both of those

1 seats flipped, and you saw the state governments then taking
2 opposite positions of what they had been taking in approaches
3 to what they had been taking before. So it is significant to
4 understand the states' roles, but to also understand that
5 states aren't deciding whether the law is going to implemented
6 or not. It is, if it's the law of the land, and our own
7 governor has said that. So I'm going to skip over federal
8 implementation.

9 There have been -- except a point, I think you tried to
10 drag in 5,000 or 6,000 pages to the Health Reform Conference
11 last week, didn't you, Dave, of all the new regulations that
12 have been put in place or proposed, or how many pages did you
13 think that -- the 34 regulations have been released, to date?

14 COMMISSIONER MORGAN: Well, the only one I brought was
15 the three sections to the Insurance Exchange. There have been
16 three -- two or three sections released. My point I was
17 making to Senator French was the Affordability Act is one
18 thing, but 12 pages out of the Affordability Act on the
19 Insurance Exchange created three sets -- well, two sets have
20 been released. The third set, I think, has been released, but
21 each one of them are above 290 pages each. So 12 pages in it
22 make 900, and I flopped that down and it didn't go over too
23 well.

24 COMMISSIONER ERICKSON: And the point about that is just
25 -- and whether that's over-regulated or not, the point about

1 that is that the law really was the what, this is what policy
2 federal government should implement to address concerns about
3 health care access affordability, quality, but getting at the
4 implementation details and how it's going to be implemented is
5 still a huge question and will continue to be a huge question
6 over a number of years, and to date, even just after the first
7 year-and-a-half, we have -- these 34 regulation packages have
8 been released in some form to describe, for us, how the
9 federal government will be implementing it and expecting
10 providers to respond, state governments to respond, other
11 payers to respond.

12 The next slide seven is just an overview of how the law
13 is structured, but what it really primarily is getting at --
14 this is not exclusively, but primarily is getting at driving
15 towards universal coverage, and universal coverage doesn't
16 mean insurance provided by government. Some people think
17 that's what it means and that's not what it means. It's
18 trying to get at, really what our goal is, I think, as a
19 Commission, is to try to figure out how we ensure access to
20 care for all Alaskans, appropriate access to high quality care
21 for all Alaskans, but this is doing it through insurance
22 mechanisms and through lots of different approaches to driving
23 coverage through insurance mechanisms.

24 So there is a whole set of private insurance market
25 reforms. Then there are the subsidies for employers who buy

1 insurance for their employers, expansion of the Medicaid
2 program, creation of the Health Insurance Exchange, the
3 marketplace, the individual mandate requirement that
4 individuals purchase and have insurance, purchase it if they
5 don't have it otherwise. The subsidies then for individuals
6 to purchase insurance and then the employer mandates. And so
7 I'm just going to quickly touch on some of these.

8 The insurance market reforms are listed on slide nine,
9 and some of them have taken effect, already took effect in
10 2010, but it was for new plans established in September of
11 2010, plans that started new benefit years after that. So
12 it's been kind of rolling, depending on if your insurance --
13 when your new -- your benefit plan started, if you have
14 insurance, whether your plan covered this or not.

15 So a couple of examples. Exclusions for pre-existing
16 conditions are prohibited. So that means insurance is not
17 allowed to deny -- starting in 2010 for children -- coverage
18 for children who have a pre-existing condition, such as
19 diabetes.

20 I did not include this note in the slide. I reviewed the
21 insurance notes that I put in with Linda Hall who had to be in
22 Paris and Italy this week and couldn't join us, but I wanted
23 to make sure I captured the insurance provisions correctly.
24 So I thought I would just note that what this has meant for 17
25 states, including ours, is that insurance -- I'm sure Jeff

1 left, knowing what I was going to say. Private insurance
2 companies no longer write child-only policies for 17 states,
3 and Alaska is one of those states.

4 So today, you can -- a private individual cannot buy a
5 private child-only plan. So my neighbors who, as a couple,
6 both work in real estate and don't have insurance coverage,
7 but have two children, ninth and second grade, they can't buy
8 an insurance plan that covers their boys now, and of course,
9 they make too much money to be covered by Medicaid.

10 On the other hand, my 20-year old son -- so to this next
11 bullet, dependent coverage extended to 26 years of age -- who
12 just decided to take a break from college -- so my insurance
13 plan otherwise wouldn't have -- to focus on his punk rock band
14 -- keep reminding me of that, Val. So now that he continues
15 on this journey, I and my husband are both able to make sure
16 he has insurance. And so while my neighbors next door can't
17 provide and purchase, even if they wanted to, insurance for
18 their children, I'm able to keep mine on. So yes, Jeff?

19 COMMISSIONER DAVIS: Sorry. I had to step out for a
20 minute. Can I add some commentary on the child-only -- or the
21 child situation?

22 A couple things. One, that was a really -- actually,
23 this probably doesn't really matter. It's not really written
24 in the law, but HHS came out and said well, this is how we're
25 interpreting what was in the law. So okay; that was nice, but

1 it caused a lot of chaos, and in some states, the result was,
2 as you described, carriers stopped selling child-only
3 policies. They'll still sell a family policy. So assuming
4 that your neighbors were insurable, they could get a family
5 policy that also covered their kids. But other states have
6 pursued a different solution, which is something that Alaska
7 could consider, which is limited open enrollment periods for
8 children and that has been worked out in a number of states,
9 and I think, you know, is an acceptable solution, but just not
10 one that has been pursued here.

11 COMMISSIONER ERICKSON: Any questions or comments about
12 the private insurance market rule changes? I'm not going to
13 go over these again in detail. There also were a number of
14 new insurance plan options created, and I just listed some of
15 the major ones here.

16 One was temporary. It was meant to provide a bridge to
17 2014 when insurers will be prohibited from pre-existing
18 condition exclusions for adults. So this was targeted at
19 adults, creating a high risk health insurance pool for folks
20 with pre-existing conditions, and the federal government set
21 those up for states that weren't interested. Our state,
22 essentially, endorsed ACHIA, our non-profit pool that we
23 already had in place, to participate in this new federal
24 program. The federal program subsidizes it, so that
25 individuals -- I think their rates can only vary based on

1 their age, and the federal program subsidizes to about 100% of
2 the standard cost of an insurance premium.

3 COMMISSIONER DAVIS: I'm intimately familiar with this
4 one. ACHIA was directed, or asked/directed, by the Governor
5 to create the program and to create the administration of it.
6 So it was actually a separate program, but it is overseen by
7 the ACHIA board, which has oversight underneath the Division
8 of Insurance and Director Hall. So the same administrator,
9 but a separate pool. And the way it works is that the rates
10 are set at 100% of market. What the Feds are subsidizing is
11 the deficit for the pool.

12 So I believe it's \$13 million set aside to get it to
13 2014. At this point, we don't think -- now just to think
14 about what happens in 2014 when there is a guarantee issue and
15 no pre-existing condition waiting periods, \$13 million set
16 aside, we believe -- our actuaries believe that what we call
17 ACHIA-feed probably would need \$39 million to go through to
18 2014, three times what was originally allocated, if enrollment
19 turns out to be the way it was, and we've asked the
20 Administrator to go back and study the people who enrolled and
21 then disenrolled because that's the behavior you would expect.
22 That's what's incented.

23 And one example that stands out of the people who've
24 enrolled and disenrolled is a -- and again she's only
25 responding to the incentives that have been given. A

1 rational, economic person enrolls, has her two preemie twins,
2 they spend three months in the hospital, they're discharged,
3 disenrolls, pays approximately \$3,500 in premium, runs up a
4 \$450,000 bill. That's what 2014 is going to look like. So
5 it's not a pretty picture, but it is the way it is.

6 And I guess one last editorial -- Colonel Friedrichs
7 isn't editorializing on this, so I get to because it's kind of
8 in my bailiwick -- is I went to a conference in Nebraska of
9 the high risk pools, since I'm the Chair of the High Risk
10 Pool, and we were talking about what they call the PCIP
11 program, the Pre-Existing Condition Insurance Pool, and it
12 just -- and they're well-meaning, you know, people who are
13 putting these things in place and talking about isn't it
14 wonderful now you can go to your doctor in the morning, and
15 you can get a letter from your doctor saying you have this
16 pre-existing condition. You can apply for the PCIP pool and
17 then be covered, and I thought that is wonderful, but this is
18 not insurance. I mean, there's nothing -- this is like my
19 house is on fire. I call Allstate and say, you know, get me a
20 plan. So I think it's important that, as we go through this,
21 we understand the financial implications of this, but we do
22 have 48 people enrolled now, and the pool is functioning well.
23 It's doing what it was intended to do.

24 COMMISSIONER ERICKSON: And Linda did mention, to me,
25 that, over the past little more than a year that it's been in

1 place, that there actually have been 66 total people enrolled.
2 So I presume that means that those are some of those people
3 who are enrolling and then dropping off.

4 COMMISSIONER DAVIS: Right. Exactly.

5 COMMISSIONER LAUFER: In all the arrows pointing to
6 universal coverage, if you meet criteria for admission or go
7 to the emergency room, you'll be seen. Everybody is actually,
8 in a sense, already insured. It's just a question of who is
9 paying for it. You're not seen at my clinic, you know, too
10 many times, if you have no capacity. So it's really a
11 question of access to primary care and then, in a few
12 instances, specialists, but hospitalization and really
13 expensive stuff, all the way to chemotherapy or surgeries,
14 we're covered. Everyone is covered. There is no incentive to
15 pay. The reimbursement for Prov's ER group is, like, 30-some
16 percent now, 32 or something. They're giving it away. Well,
17 they're passing the bill to Jeff again.

18 COMMISSIONER ERICKSON: Moving on, more related to the
19 insurance market reforms. This is an issue that was in the
20 news a while back, the requirements for review of health plan
21 premiums. There was a little bit of a flare-up because the
22 state of Alaska declined the federal funds that were made
23 available to all states to participate in this program, and
24 for this one, we might have actually been the only state.
25 However, the Administration did not feel as though those funds

1 were necessary. What they needed was an expansion of their
2 authority, and they received that through passage of House
3 Bill 164 this past year, expanded their authority to pre-
4 approve rate increases for all private health insurers
5 operating in Alaska, and I think, because of that and because
6 Linda felt as though she had sufficient capacity within her
7 agency and didn't need federal funds to help with that, but
8 the Feds did come in and review that program, along with other
9 programs nationwide, all of the states, and Alaska was one of
10 the states -- not all states were -- deemed by them as having
11 an effective review program. So that is in place now here.

12 Another federal grant that Linda decided she really
13 didn't need help with after conferring with her staff was
14 federal funds to set up a state consumer assistance program,
15 and she has an existing program in place. She felt that that
16 was fully staffed and adequate to meet any increased demand
17 that might come about as a result of any of the changes that
18 were happening under the Affordable Care Act. So there is a
19 consumer assistance program in place. I refer folks to it all
20 the time.

21 As far as employer subsidies, those started kicking in
22 for the smallest employers, those with fewer than 25 employees
23 and an average annual wage of below \$50,000 for the 2010 tax
24 year, and that will expand in 2014. There also was a
25 temporary early retiree reinsurance program created under the

1 Affordable Care Act. Again this was another bridge program
2 that was meant to get to 2014 when a lot of the expansion
3 provisions take effect, but that was meant to incentivize
4 employers who have retiree insurance programs to keep those
5 for the early retirees, folks between the ages of 55 and 65,
6 and we have eight large employers enrolled in that right now,
7 and over a million dollars has been received by them, as of
8 this past month.

9 Medicaid expansion will take effect in 2014. It expands
10 eligibility for individuals and families under 65 years of age
11 up to 133% of the federal poverty level, and the federal
12 government will pick up most of the cost of that expansion,
13 all of the cost until 2017 and then it starts phasing in the
14 State's share in 2017 and reaches a maximum of 10% for the
15 expansion population, again, specifically. This is pretty low
16 compared to some of the estimates we've seen. It was kind of
17 a midrange estimate that the Department of Health and Social
18 Services came out with early on, and I haven't gone in and
19 updated it. About 30,000 new enrollees expected. I've seen
20 estimates as high as, I think, 45,000 at the most.

21 There have been -- well, okay. The Health Insurance
22 Exchange. Dave was just updating us on the status of the
23 regulations there, but this is really meant to be an
24 electronic marketplace for shopping for insurance and making
25 it easy to purchase insurance, but it also is the mechanism

1 through which folks will access the subsidies. The
2 individuals and small businesses will access the federal
3 government subsidies, and it's also meant to provide kind of a
4 portal for eligibility for public programs, like Medicaid, as
5 well and to interface with the Medicaid program eligibility
6 and enrollment system. These are -- states are encouraged,
7 but not required to set it up for their state. They will be
8 state-based. The states have an option to create multi-state
9 exchanges. So states could partner with other states. State
10 government could administer them or non-profits. If a state
11 chooses not to set one up for their state, if state government
12 chooses not to, then the federal government will establish the
13 exchange for the state. And they're required to be self-
14 sustaining by the following year. They're to kick in, take
15 effect in January of 2014, and they're to be self-sustaining
16 by 2015. Secretary Sebelius is required under the law to make
17 a determination at the beginning of 2013 for each state
18 whether they're going to be prepared to implement their
19 exchange for their state or not and so that will happen in
20 about a year-and-a-half, and she's required to start working
21 on setting up an exchange for those states that she determines
22 will not be ready.

23 We are one of few, if not the only, state to have
24 declined federal funds for planning an Insurance Exchange.
25 Our Administration felt that the requirements that came along

1 with those funds were unnecessary and potentially burdensome,
2 and there are concerns about whether provisions related to the
3 individual mandate were constitutional are not played into
4 that as well. However, the Department of Health and Social
5 Services and the Department of Commerce and Economic
6 Development, Division of Insurance are partnering together to
7 look into and investigate options related to the Exchange, and
8 right now, are looking at getting more information to better
9 informed decisions related to what Alaska will do and how
10 Alaska will proceed related to exchange.

11 So the Department released an RFP just this past month
12 and are hoping to have the contract awarded by the beginning
13 of November. I included the scope of work for that contract
14 from the RFP in your notebooks. It's posted on the Web. And
15 really, I thought that you would be interested in seeing, as
16 we plan for what we're going to study next year, the type of
17 data that this consultant will be pulling together, some of
18 which will be really relevant to our continuing work. So not
19 so much that I thought you might be interested about what's
20 going on with the Exchange as you might be interested to see
21 some of the assessment work that's going to happen related to
22 the Exchange, and we can follow that.

23 Ward is looking at his watch, so I'm going to.....

24 CHAIR HURLBURT: Yeah (affirmative). You're not quite
25 half done with the slides.

1 COMMISSIONER ERICKSON: Well, I'm skipping the ones that
2 don't have anything specific to Alaska.

3 COMMISSIONER STREUR: Deb, why don't you just focus on
4 the stuff going forward?

5 COMMISSIONER ERICKSON: Well, that's what -- I've skipped
6 to the Health Care Delivery. So there are -- related to the
7 primary care enhancement and community health centers. Since
8 we've been very focused on primary care, I thought you'd be
9 interested in seeing -- and also primary care and behavioral
10 health integration. There have been a couple of grants
11 awarded under the Affordable Care Act in Alaska, one to Alaska
12 Islands Community Services in Wrangell and the SouthCentral
13 Foundation, specifically to support primary care and
14 behavioral health service integration.

15 There have been 13 community health centers just this
16 past month that received grant awards of \$35,000 each to
17 support their transition to patient-centered medical homes.
18 There also is a number of other grants awarded to support
19 development and expansion of community health center services
20 in the state. There are funds available or a Medicaid option
21 that would provide a match of 90%. Our match, for your
22 benefit, Allen, right now is about 50% federal/state for
23 Medicaid services. This would provide a 90% match for two
24 years, and I would assume, I'm sure, that our state's Medicaid
25 program will be interested in that when they feel that we're

1 at the point to pursue that option. An important point about
2 is that the clock starts ticking two years -- as soon as the
3 Feds approve it, and it's only good for two years. So
4 they're, I'm sure, are waiting until we have a program fully
5 in place before they move forward with implementing that state
6 option.

7 There are a number of payment reform provisions. I think
8 one thing that's important to note related to payment reform
9 is, through the Affordable Care Act, the federal government is
10 going to be testing out lots of different models. They,
11 mostly, are demonstration and pilot programs that they'll be
12 testing. They created a new agency in the Medicaid/Medicare -
13 - the Center for Medicaid/Medicare called the Center for
14 Medicaid & Medicare Innovation that's charged with testing a
15 variety of payment reform models and determining what are
16 effective.

17 There are also a number of provisions affecting rates,
18 and one of those, creation of a new Payment Advisory Board
19 specifically for Medicare, something that's causing some
20 anxiety. Folks are watching closely. But there really isn't
21 anything specific to report for our state now, unless we
22 wanted to get into some of the details around some of the
23 things that will take effect or that are taking effect, like
24 the hospital value-based purchasing program, some other
25 payment adjustments that are going to be made over the coming

1 years and some of which are taking effect now.

2 Just a note, there are a number of grant programs. Some
3 of them were programs that have been in place for 20 or 30
4 years for prevention and public health that were rolled into
5 the Affordable Care Act. There are also a number of new
6 programs. We've continued to receive grants under the
7 existing programs and also have received some grants under new
8 programs as well. We'll go over those in detail.

9 Related to workforce, there was -- I meant to ask our
10 Coalition folks this morning this question, if they were
11 tracking what was going on with the National Health Care
12 Workforce Assessment, but the Act did create one of the new
13 agencies that's already up and running as a National Health
14 Care Workforce Commission, and they were charged with
15 assessing the National Health Care Workforce and were supposed
16 to have been doing that this year. I think that assessment
17 actually was supposed to be out by now, but I haven't seen it.

18 The National Service Corps was doubled. Funding was made
19 available to states to conduct workforce planning. The grant
20 that was referenced this morning that our Department of Labor
21 has just completed with the support of the Health Workforce
22 Coalition was awarded under that program.

23 A lot is going on with fraud and abuse, and I included
24 this slide for the Health Care Compliance Association that I
25 gave this presentation to earlier this year. 2011 was the

1 year that many of the provisions -- there are 32 sections on
2 health care fraud and abuse, a whole title in the Act devoted
3 to that, and most of those are taking effect this year. And
4 so I've listed those general areas of new requirements on this
5 slide.

6 One of the things that I wanted to note especially
7 specific to our Medicaid program in the Department of Health
8 and Social Services, the program that this group likes to
9 refer to as the Bounty Hunters, the Medicare RAC program, the
10 Recovery Audit Contractors, that program was required under
11 the Affordable Care Act to be expanded to all Medicaid
12 programs in the state, and regulations were released just this
13 past month by the federal government. State Medicaid programs
14 are required to implement their new RAC programs by January,
15 this January, and our program is working on trying to figure
16 out how to align the Medicaid RAC program with other Medicaid
17 audit requirements that are required under state law in order
18 to minimize, to the extent they're able, to the impact on
19 providers of the multiple programs.

20 I'm going to skip the CLASS Act. I'm going to skip over
21 how the Act pays for itself, although in your handouts, there
22 are six bricks showing different ways, both in terms of new
23 revenue and savings. The Act is meant to pay for itself, and
24 the Commissioner reminded me that I was leaving one out. So I
25 actually added a couple more in terms of new taxes and fees

1 and then savings through fraud and abuse and through
2 achievements that the health care delivery reforms and the
3 payment reforms are meant to achieve. I've listed the new
4 fees and taxes, which are mostly on industry and also on high
5 income individuals, industry being the health care industry
6 specifically, the insurance industry, pharmaceutical industry,
7 and some others. Let's see. I don't think we need to go over
8 that.

9 The Commission contracted this past year with ICER to do
10 kind of a big picture economic impact for the state, and Mark
11 Foster had made a couple of presentations to us over the past
12 year, and you have those chart packs, but he also produced for
13 us a couple of months ago -- I actually got it in August, and
14 I included it in your notebooks this time -- a final narrative
15 report from him, but I just pulled a couple of the main points
16 over. Total spending, how we would expect overall spending to
17 change for health care in the state and how we expect
18 insurance coverage to change with the implementation of the
19 Act, just as a general impact in Alaska statement and then
20 included a timeline at the end of when things are taking
21 effect.

22 So with that, does anybody have any questions for me or
23 for the Commissioner? Yes, Val?

24 COMMISSIONER DAVIDSON: I didn't have a question. I just
25 wanted to compliment you for providing this information. I

1 think you provided it in a really nutshell. I think the
2 timelines were really valuable, and the piece that we've
3 really been missing that you captured in snippets was, how was
4 the state responding, are we choosing or not choosing for a
5 variety of reasons to avail ourselves of funds, et cetera, and
6 just so that people have a snapshot of where we are, so thank
7 you very much for providing that.

8 COMMISSIONER ERICKSON: Thank you. You're welcome.

9 COMMISSIONER STREUR: That was the easy part. The hard
10 part is that -- well, getting to Deb to do that in a half-hour
11 is not an easy part; I have to admit that.

12 But seriously, what we're facing is, between now and
13 2014, we have 63 milestones in the Affordable Care Act that
14 we're going to be tasked with implementing or have already
15 implemented since July 1 of this year. Compare that with
16 2016, '17, '18 -- '15, '16, '17, and '18. There are three.

17 So the lion's share of what we are going to be doing in
18 the state of Alaska with the Affordable Care Act is going to
19 be happening in the next three years. It's going to be
20 happening at a rapid pace. It's going to be painful. It's
21 going to be hard. It's going to be difficult. It's going to
22 be challenging. For some, it's going to be exciting. Me,
23 being the external cynic about the Affordable Care Act
24 changing 90 years of the way we do business in a short four-
25 year timeframe. It causes me to have a fair amount of

1 cynicism, but there is a big task before us.

2 The Medicaid expansion. The Medicaid expansion is going
3 to change the way we fund many of the providers in the state
4 of Alaska. If you look at parity, if you look at Medicaid
5 expansion and the behavioral health system, they aren't going
6 to recognize the way that they do things now and that's just
7 going -- I mean, continuous change for us over the next
8 timeframe, but with that, listening to you all today, I kind
9 of remarked to Keith I was happy to hear myself quoted so many
10 times. So that's either a good thing or a bad thing. But I
11 have committed, Commissioner Hultberg has committed to working
12 with the provider system, the delivery system, if you will,
13 working with our partners in the insurance industry to find
14 out a way to affect, in a good sense, the way we provide
15 health care, to not gore oxen, but to roast an ox and do it
16 together and do it side-by-side and figure out a way to do
17 this because it's not going to be something that the state of
18 Alaska can do, Blue Cross can do, Commissioner Hultberg can do
19 through leveraging the employees and workman's comp staff of
20 the state. It has to be people getting together and
21 understanding that there needs to be sacrifice across the
22 board. With that sacrifice, hopefully, we'll come out with
23 some wins.

24 Another quote that I heard was right care, right time,
25 right place, right people, for the right price, and you know,

1 getting to that point. I'm not sure that what we heard this
2 morning necessarily gave us any magic bullets to look at what
3 we're going to do going forward, but I think it's the
4 beginning of an analysis that we have to continue to do and
5 try to find out, you know, if there is a solution to that.
6 Nobody's got the answer, and I'm just going to say that. I
7 haven't seen anybody out there. I've listened to the Don
8 Berwicks and the other geniuses out there, and everybody has
9 got an idea, but you know, it's tough to do, and we need to
10 find out a way to affect the size of the balloon, the size of
11 the dollar spend that we have without either popping the
12 balloon or making it push out in another area because, right
13 now, the remedies that I'm seeing to fixing health care are
14 about pushing the balloon. And when we push from one point,
15 it's going to push out in another spot, and all we're doing is
16 changing the shape.

17 So you know, with that, I encourage, ask, implore, beg
18 you all to stay engaged because this is going to be tough, and
19 for those of us that have taken it on, you know, Ward and I
20 are getting a little old for this, but for those of us that
21 are taking it on, it is a challenge. The state of Alaska
22 doesn't much care for the Affordable Care Act. For those of
23 you, that's news. It doesn't much care for the Affordable
24 Care Act, but as long as it is the law of the land, we are
25 going to work toward implementation. That's why you're seeing

1 the RFP for the consultant, for the Insurance Exchange.
2 That's why you see us taking other -- assuming other
3 activities related to the Affordable Care Act because until it
4 is reversed, until it disappears, until there is a change of
5 leadership or something at the federal level, you know, we are
6 going to continue to move forward. And even if there are
7 parts of it that are reversed, there are some parts of it that
8 are not going to be able to be reversed. You know, the
9 changes are already in motion, and I don't think that getting
10 rid of the Act is necessarily going to get rid of it.

11 So with that, I will stop and see if there are any
12 questions, but remember 63 milestones.

13 COMMISSIONER CAMPBELL: Given that you're moving forward,
14 are all your internal systems robust enough at this point to
15 do your MMIS or whatever else you need?

16 COMMISSIONER STREUR: Short answer, no. The EIS system,
17 the eligibility system, is a 30-year old system. It's older
18 than the MMIS system is, and it does twice-a-week updates.
19 It's pretty antiquated. You know, I'm hopeful that, you know
20 if this thing goes ahead, that, by 2014, we, at least, have
21 some inkling of when we'll be able to handle the expansion
22 with the new system because I don't think the old system will
23 handle it, not without considerable manual expense.

24 COMMISSIONER DAVIDSON: But those were, in a sense, pre-
25 existing conditions, right? I mean, those were systems that

1 had been antiquated. The Affordable Care Act didn't make them
2 antiquated. They were antiquated to begin with, and because
3 we, collectively as a state, didn't invest in that
4 infrastructure, it's sort of been limping along, but now that
5 the Affordable Care Act is requiring all of these changes to
6 happen, then it's sort of exacerbating and highlighting the
7 issue.

8 COMMISSIONER STREUR: Point well-taken. We were already
9 working towards a new EIS system, just as with a new MMIS
10 system, prior to this happening, and yeah (affirmative). It
11 needed to happen. Most states will turn both an EIS and an
12 MMIS system every ten to 12 years; 27 and 30 years is what we
13 did.

14 COMMISSIONER BRANCO: Commissioner, I know you spent a
15 little bit of time with Secretary Sebelius when she was here
16 and the Governor did as well. What was your takeaway? I
17 think it was her first trip to Alaska, and I think we all
18 agree we're fairly unique. What would you say were your
19 takeaways in helping expand her understanding of the provision
20 of care here?

21 COMMISSIONER STREUR: Well first of all, the time that we
22 spent with her was about ten minutes.

23 COMMISSIONER BRANCO: The Press made it longer.

24 COMMISSIONER STREUR: And we told her that we were glad
25 that she was here, and she said we're here to help you.

1 You've heard that, you know. But yeah (affirmative), tongue-
2 in-cheek aside, she expressed a commitment and a willingness
3 to work with the state of Alaska to improve and change the way
4 we deliver Medicaid services. We didn't get, really, to touch
5 on much of anything, other than talked a little bit about
6 waivers, did not talk about (indiscernible - voice lowered)
7 grant at all, but I mean, it was a cordial meeting. It was an
8 open meeting. There has been follow-up already back to me
9 after the meeting, even though it was that short of a
10 timeframe, but a nice, cordial meeting.

11 COMMISSIONER MORGAN: I have just one question, which I
12 know we're going to -- I know that your agency -- that your
13 department will be giving out four RFPs for medical home pilot
14 projects. What's the timeline on that? I was asked by the
15 Chair of the Primary Care Association.

16 COMMISSIONER STREUR: That timeline is still in
17 development because we want to bring in a consultant to help
18 us to do this right and to put it together, to, you know, work
19 at what the head tax should be, in other words, what we pay a
20 primary care provider to do this, to make sure that we have a
21 strong primary care-driven orientation with it, and to make
22 sure that the pilots that we use are set up and capable
23 because we're only going to be able to get one run at this.

24 COMMISSIONER KELLER: Fools rush in. I'm going to make a
25 statement. This is not a Democrat/Republican issue that we're

1 facing on health care reform. It's a very, very serious
2 situation that we're in. You made the case over and over
3 again of a boat sinking. You know, we better bail. It's just
4 interesting, to me, that every Republican candidate -- I heard
5 them personally last week; I was in D.C. -- has vowed to
6 repeal Obama Care, if they're in. We can't let that affect
7 us, as a Commission. We have health care reform to do, and
8 you know, it's just fascinating, to me, that our perception
9 here over the next six to eight months, you know -- we're in
10 for a ride, you know, to watch what happens, but our task is
11 constant.

12 CHAIR HURLBURT: Anything else? Thank you, Commissioner.
13 Thank you, Deb. Breakfast at 7:30?

14 COMMISSIONER ERICKSON: Breakfast at 7:30. So homework
15 for tonight: think about any other takeaways from the
16 presentations today you want to make sure get captured. I
17 will do a little bit of synthesizing. It's not going to be --
18 it will be far from perfect of the bullets we pulled together
19 this afternoon, but we'll have all morning tomorrow to work on
20 our existing statements. Take a look at those in your
21 notebook. They're behind tab two. So any changes you might
22 to our current drafts, tomorrow will be the time to work on
23 that.

24 The other I'd ask you to do, too, is look at the list on
25 our agenda, the last page of our agenda, the parking lot ideas

1 for our 2012 agenda and see if there is something missing from
2 there and how you might prioritize those issues, so we can
3 stay focused and figure out how to invest our time and our
4 resources for the next calendar year as well.

5 Any questions or comments for the good of the order
6 before we adjourn just for the day or recess for the day, I
7 guess? Thank you.

8 4:46:08

9 (Off record)

10 **SESSION RECESSED**

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