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ALASKA HEALTH CARE COMMISSION
FRONTIER BUILDING, ROOM 896
3601 "C" STREET
ANCHORAGE, ALASKA
MONDAY, DECEMBER 10, 2012
8:02 A.M.

1 doing reasonably well in Alaska, so thank you.

2 I've read probably a dozen books related to this over the
3 past year, and I think you -- at least, two of these you'll be
4 aware of. I want to mention the four that I think are the
5 best. A couple of them you've heard before. If any of these
6 four you have not read and you think you would like to read,
7 the Commission can buy them for you.

8 This is the one from our October meeting, "The Company
9 That Solved Healthcare," but this tells about the company
10 there in Wisconsin that basically worked to align the
11 interests of the employer and the employee in terms of access,
12 in terms of quality, in terms of costs of healthcare, and I
13 thought it was quite good.

14 This is the one that I've mentioned before. If there any
15 one book, "Tracking Medicine," this is the one by John
16 Wennberg, who was in Dartmouth at the Institute. He is kind
17 of semi-retired or emeritus now. But this is the one that
18 shows the wide variation in clinical practice in rates of
19 procedures and numbers of procedure and so on, starting out
20 with his early studies in Vermont, in communities 20 miles
21 apart. Did you do lots of T&As because you had a doc that got
22 messed up when he gave people tonsils? Or did you not need to
23 do so many there? And then he found that true nationally, and
24 this is -- it's not a fast read, but I think it's fascinating,
25 and it really shows the opportunity for more evidence-based,

1 more science-based medical practice in a way that, I think, we
2 end up saying we have lots of resources, plenty of resources.
3 We've talked about issues and challenges.

4 This is kind of a book by a cynic, and this is by Gill
5 Welch. Gill, I knew as a General Medical Officer out in
6 Bethel back in the early '80s, I think, and now he is actually
7 there at Dartmouth. And Gill was up here at UAA and made a
8 presentation. He is not a therapeutic nihilist, but the.....

9 COMMISSIONER ERICKSON: Ward, mention the title.

10 CHAIR HURLBURT: It's "Over Diagnosed" is the title by
11 Dr. H. Gilbert Welch, "Making People Sick in the Pursuit of
12 Health." But his thesis is that, as we have expanded our
13 ability to do screening and testing, we haven't always done
14 good. And there are no urologists in the room, but if there
15 were, they would vigorously disagree with me, but I've only
16 had my PSA done one time and that was probably by accident.
17 But as Gill points out, a lot of problems -- a lot of harm was
18 caused by overaggressive reaction to something that probably
19 would not have caused pain, and he gets into a number of other
20 things. As I say, it's a bit of a cynical approach, but he is
21 not a therapeutic nihilist. If you really have something,
22 then you need to get good care.

23 And then this one was recommended -- delighted me -- by
24 Jim's boss, so maybe Jim has read it -- by Becky Hultberg, the
25 Commissioner of Administration on "The Innovator's

1 Prescription" by a guy named Clayton Christensen. And his
2 thesis is that what we need in healthcare is disruptive
3 technology, and you have to read it to understand what he
4 means by that, but in a sense, it relates to a conversation
5 that Larry and I were just having, for example, on traumatic
6 brain injury where Larry was describing the center, the
7 resource-intensive center at the Mayo Clinic where, in order
8 to support that kind of a center, you need ten or 15 new
9 patients coming along every week for a very serious where
10 medicine has something, sometimes miraculous things to offer.
11 But basically, he is saying that there are a lot of things
12 that would be better centralizing, and looking at what he
13 calls disruptive technology.

14 So the dozen or so books that I have read, I would
15 recommend all of these four to all of you, and if there is any
16 one or all of them that you do not have or haven't read and if
17 you think you would read it, just let Deb know. I'll leave
18 them here for now, and I think they would be worth your while
19 as we all continue to learn about what we're doing here.

20 Let's go around and just everybody introduce ourselves.
21 There will be no public testimony, as we have during our usual
22 meetings here, but we do have the record that the originals of
23 public testimony in the files and then Deb nicely summarized
24 it for us. So for the record, if you could just identify
25 yourself and who you represent here? David, can we start with

1 you?

2 COMMISSIONER MORGAN: Dave Morgan representing primary
3 care facilities and Association.

4 COMMISSIONER STINSON: Larry Stinson, a physician
5 representing physicians and other healthcare providers in
6 Alaska.

7 COMMISSIONER KELLER: Wes Keller. I'm the voting link to
8 the State House.

9 COMMISSIONER CAMPBELL: Keith Campbell. I am the
10 consumer representation. I reside in Seward.

11 COMMISSIONER PUCKETT: Jim Puckett. I'm a non-voting
12 participant representing the Office of the Governor.

13 COMMISSIONER URATA: Bob Urata, primary care physicians.

14 COMMISSIONER BRANCO: Pat Branco. I'm a voting member,
15 and I represent the Alaska State Hospital and Nursing Home
16 Association.

17 COMMISSIONER DAVIDSON: Good morning, (indiscernible -
18 speaking Native tongue), Valerie Davidson representing tribal
19 health.

20 COMMISSIONER ENNIS: Emily Ennis representing the Alaska
21 Mental Health Trust.

22 COMMISSIONER HARRELL: Yes. Good morning, I'm Dr.
23 Harrell. I'm the Commander of the hospital out at JBER.

24 COMMISSIONER DAVIS: Jeff Davis, President Premera Blue
25 Cross Blue Shield of Alaska. I'm representing insurers, and

1 hopefully, representing the interests of all Alaskans.

2 COMMISSIONER ERICKSON: Deb Erickson, staff to the
3 Commission.

4 CHAIR HURLBURT: And I'm Ward Hurlburt, the Chief Medical
5 Officer with the Department of Health & Social Services and
6 the designated Chair.

7 While we won't have time that's scheduled -- and we don't
8 normally for this meeting -- for public testimony, I wonder if
9 we could just, for the record, have you folks who are here now
10 -- and I know others will be coming -- just introduce
11 yourselves, and if you are representing somebody, if you could
12 say? Rick, we'll start with you in the back and come forward.

13 MR. BENJAMIN: Thank you. Good morning, Rick Benjamin
14 from Hope Community Resources.

15 MS. SENNER: Patricia Senner from Alaska Nurses
16 Association.

17 MS. HEFFERN: Sandra Heffern with EHD Enterprises.

18 MS. BRADY: And I'm Kennis Brady with the Primary Care
19 Association.

20 MS. HUDSON: Laura with APS.

21 MR. PARAYNO: My name is Ronnie Parayno. I'm a
22 researcher from UAA.

23 UNIDENTIFIED MALE: (Indiscernible - away from mic)

24 UNIDENTIFIED FEMALE: (Indiscernible - away from mic)

25 CHAIR HURLBURT: Welcome, everybody, here. Thank you for

1 being here. Deb, do you want to go ahead and.....

2 COMMISSIONER ERICKSON: Yep. Let's go ahead and get
3 started, but let me make just a few -- a couple quick
4 announcements first. First, I wanted to point out that you
5 all received a Christmas gift from Commissioner Morgan and his
6 lovely wife. The fruit basket on the table back here is from
7 Dave. So I just wanted to mention that to you.

8 Also for folks on the phone, all of the handouts that the
9 Commissioners have in their packets are posted on the Web.
10 They were posted on Friday. There is a Meeting Discussion
11 guide PowerPoint that will be posted this morning. If it's
12 not up yet, it will be any minute now.

13 And for folks in the room, everything that the Commission
14 members have in their packets are available as handouts on the
15 back table, except the full body of the comments that were
16 received. The Commission members received all of those last
17 week and had a chance to review them. They're posted on our
18 website as well, but it was a thick enough packet that I
19 didn't want to kill too many trees. So you'll have to access
20 that particular document. There is a summary of the public
21 comments as well as a copy of the draft report and the
22 discussion guide on the back table for folks -- members of the
23 public who are attending in the back of the room.

24 I think that's it for announcements, so why don't we go
25 ahead and dive into our agenda? And before we start going

1 through the report, I thought it was important to take a
2 couple minutes to revisit, again, and eventually have a
3 conversation, if there are questions, the framework role and
4 context for the Commission's work and what we're doing and
5 where we're at. And so we're going to actually start and take
6 maybe ten or 15 minutes to do that before we dive into the
7 report. What are you looking for?

8 COMMISSIONER DAVIS: I got it.

9 COMMISSIONER ERICKSON: Got it. Very good.

10 COMMISSIONER DAVIS: I didn't know it's double-sided.
11 Sorry.

12 COMMISSIONER ERICKSON: I was getting a confused look.
13 Yeah. It's printed double-sided. And then as far as our
14 plans for today, our concern -- then we'll spend the majority
15 of our time today going through public comments and giving you
16 all an opportunity to make any changes that you might like to
17 make as a result of the comments that we've received or
18 anything else you've learned or considered in the interim,
19 since we put the draft together.

20 We will spend a little bit of time at the end of the
21 meeting with our usual update on the Affordable Care Act.
22 Commissioner Streur is traveling today and isn't available,
23 but I've just put together a slide with some significant
24 things that have happened in the past two months since we met
25 last. It's just a quick update. And then we will talk about

1 next steps and how we're wrapping up for this year and a
2 little bit about our plans for next year.

3 CONFERENCE OPERATOR: This is the conference operator;
4 can anyone hear me?

5 COMMISSIONER ERICKSON: Yes. We can. Hello, can you
6 hear us?

7 CONFERENCE OPERATOR: This is the conference operator; is
8 there anyone on the line?

9 COMMISSIONER ERICKSON: Yes, but obviously, you can't
10 hear us. And I've lost.....

11 (Pause)

12 COMMISSIONER ERICKSON: We'll hopefully get that fixed.
13 Well, after that announcement for folks on the phone, they
14 maybe couldn't hear it. Do you think it is the phone line?

15 CONFERENCE OPERATOR: This is the conference operator;
16 can anyone hear me?

17 IMIG TECHNICIAN: Yes.

18 COMMISSIONER ERICKSON: We'll take a quick technical
19 break because it's not worth trying to talk through this, if
20 anybody needs another cup of coffee.

21 8:15:46

22 (Off record)

23 (On record)

24 8:16:32

25 COMMISSIONER ERICKSON: So first, let's just take a

1 couple of minutes to revisit the Commission, our role, and
2 what we are and what we aren't. We had this conversation -- I
3 actually took the slide and updated it a little bit -- a
4 little over a year ago, but it's something that, I think, is
5 important for us, as a group, to revisit periodically, our
6 role and how we're functioning.

7 And I was just reminded recently in a conversation I was
8 having with leaders of the Alaska Healthcare Workforce
9 Coalition, and they're trying to refresh and regroup and
10 figure out what their future is going to be. And so we were
11 talking about the difference between a collaborative and a
12 coalition, the work of the Commission and so that was fresh in
13 my mind.

14 And the way that I've defined collaborative or a
15 coalition in the past is a collaborative being a partnership
16 of representatives of organizations that are working together
17 towards a common goal and are coming together to bring
18 resources to the table, essentially, either the ability to
19 make some sort of actual policy change in practice or
20 contribute financial resources.

21 And a coalition might be a particular group, folks
22 interested in working together towards a common goal who
23 aren't necessarily able to bring resources to the table, but
24 want to unite their voices and a common interest in learning
25 about a particular issue or set of issues and advocating for

1 those.

2 So the Health Care Commission was really established --
3 and the way we're functioning -- to be more of a study group
4 and an independent group. I actually had a senior policy
5 leader question why we would circulate our draft for public
6 comment during the public comment period.

7 So I mean, this was one person's perspective, but from
8 this person's perspective, they thought that we should be
9 trying to remain as independent and objective as possible,
10 that we're not a legislative body. We're not making policy.
11 We're recommending policy. And that we needed to be
12 objective, and I pushed back on that. I disagree. I said, I
13 think my sense is -- and we can talk about this going into
14 next year, too, about -- we can revisit process and talk about
15 how we are organizing our meetings with holding a public
16 hearing at every meeting, which we're not required to do, and
17 this process that we've kind of started, this tradition we've
18 started of putting our draft out for public comment, which
19 we're not required to do either. But I think we're striking
20 the -- I feel as though we're striking the appropriate
21 balance, that it's important to hear other people's voices,
22 and while we have a good group of brains around the table,
23 that we might get an idea that we wouldn't have thought of
24 before, too.

25 So my sense is it's been the right thing to do and we're

1 striking the right balance, but I just wanted you to know that
2 there are some senior policy leaders that really do -- the
3 expectation is that we're going to be objective and do our
4 best thinking around the challenges that we face with the
5 healthcare system and be as objective as possible in bringing
6 recommendations to the Legislature and the Governor.

7 One of the things that this group decided when they were
8 still under an Administrative Order was that the group would
9 never respond to legislation, that we wouldn't study and take
10 positions on that, in part, so we wouldn't -- to avoid getting
11 politicized. The greater reason was that we really needed to
12 be proactive and not reactive and that we would spend all of
13 our time and limited resources studying and reacting to other
14 legislation, if we didn't draw a real hard line in the sand
15 that we're going to do that, federal or state, that we're not
16 responding to other people's ideas that we are being creative
17 in trying to address this problem and coming up with our own
18 ideas and our policy recommendations.

19 The other thing that is, I'm imagining, hard for a lot of
20 folks at the table, just because you're all leaders in the
21 organizations and sectors where you work, it's hard to not
22 think of ourselves as the group of people who are going to
23 actually do something about the problem, that we really are
24 just advisory and that we have no authority to do anything at
25 all and very limited resources.

1 The other thing that we have stressed, over time, is that
2 we need this group to stay at the 50,000-foot level in making
3 policy recommendations about what state government should do
4 and trying to draw the line. It's not always as easy to draw
5 this line as clearly between how state government should do
6 something. And I'm getting into implementation and
7 operational recommendations, that we don't have enough
8 information to make decisions or to come up with advice
9 regarding how a state agency might move forward with
10 implementing one of these policy recommendations and aren't
11 responsible or accountable either. So that's getting a little
12 too far down in the weeds, too. It would take too much time.

13 So just in terms of framework for our role and our
14 guiding principles, questions? One from Keith -- or comments?

15 COMMISSIONER CAMPBELL: Going back to your previous
16 statements in your conversation with the policymaker, am I to
17 assume that his or her particular emphasis wasn't being made
18 solid enough by this Commission or was this a general
19 oversight or overview of the Commission's work?

20 COMMISSIONER ERICKSON: It was specific to circulating
21 the draft for public comment, and I'm not understanding your
22 question, Keith.

23 COMMISSIONER CAMPBELL: My question was whether they had
24 a particular point of view that they would like to have
25 emphasized more by this Commission?

1 COMMISSIONER ERICKSON: Oh, no. No, no, no, no. No. It
2 was just about process. Yes, Val?

3 COMMISSIONER DAVIDSON: So I just have to say that I just
4 find this slide really surprising and a little bit -- some of
5 the language is really offensive, "avoiding the tyranny of the
6 urgent." I think that, if you look at -- I'm not really sure
7 the language in some of these observations is really
8 appropriate. I think that, if you look at our statutory
9 charge, which was approved by the Legislature long after there
10 was an informal or an Administrative Order creating the
11 Commission, the Legislature's directive was very clear, and it
12 is in the statutory charge in 18.09.010 and .070, and it is,

13 "The purpose of the Commission is to provide
14 recommendations for and foster the development of a
15 statewide plan to address the quality, accessibility, and
16 availability of health care for all citizens of the
17 state. We serve as a health planning and coordinating
18 body. Consistent with state and federal law, the
19 Commission shall provide recommendations for and foster
20 the development of a statewide health plan containing the
21 following: comprehensive health care policy, strategy
22 for improving the health of the all residents....."

23 There is a host of subsections there. The Commission may
24 hold public meetings, and we need to submit a report to the
25 Governor and the Legislature by January 15th. I think those

1 things are all absolutely clear in the direction provided by
2 the Legislature, and I think a lot of the things -- some of
3 the things in this slide are offensive, and a lot of it is
4 really unnecessary. I think the statute is very clear.

5 COMMISSIONER ERICKSON: Well, I want to apologize if you
6 find the comment -- obviously, you do find the comment -- that
7 you find the comment about the "tyranny of the urgent"
8 offensive. That is a term that's commonly used in management
9 to remind the team -- it's a term that I'm used to using in
10 management to help the leadership team stay focused on policy
11 direction and spend time planning for the future and taking
12 more of a systems view rather than getting caught up in the
13 day-to-day crises that every leader and manager faces. And so
14 anybody who is in a leadership or a management position is
15 subject to, everyday, getting caught up with those day-to-day
16 crises and have to remind themselves periodically to step back
17 and consider the big picture and the forward view. And that's
18 a term that I've heard used to remind leaders and managers of
19 that point, for a couple of decades. So I don't know -- I see
20 a couple of other heads around the table nodding -- if you're
21 used to hearing that, that phrase. So other folks are used to
22 hearing it, and I'm sorry that you find it offensive, Val.
23 But do you understand the point that that statement is trying
24 to make though?

25 COMMISSIONER DAVIDSON: I just think the slide is

1 unnecessary. I mean, our statutory -- our requirement for
2 what we're doing here is pretty obvious. We have guiding
3 principles. Those are not them.

4 COMMISSIONER ERICKSON: Well.....

5 COMMISSIONER DAVIDSON: They're outlined clearly and have
6 been approved by this Commission, and they are not -- that is
7 not them.

8 COMMISSIONER ERICKSON: Well.....

9 COMMISSIONER DAVIDSON: And I think we should be
10 consistent.

11 COMMISSIONER ERICKSON: So we -- this isn't specific to
12 the group's charge, but it's about process, and it's -- one of
13 the tensions that we face with this group is that we have
14 limited time and resources and we have a role that is just
15 advisory to senior policy leaders. And so I guess I'm pushing
16 back a little bit, Val, but I think it's really important for
17 us to be clear about -- as clear as possible about role and
18 process. Does anybody have any -- and I guess another point
19 about our statute is that it's so broad that this group can't
20 possibly address and develop recommendations regarding every
21 single point that's in that. And so we're trying to keep the
22 -- help the group stay as focused as possible on the most
23 critical issues and something that need to be doing something
24 about. So.....

25 CHAIR HURLBURT: I wonder, Val, could you maybe be

1 specific where you see any variance between this and what's in
2 the statute because I didn't -- you know, as I would hear it,
3 I didn't pick up that it was a variance of the statute, but
4 you're lawyered; I'm not. So may have some expertise there.

5 COMMISSIONER DAVIDSON: I guess my point was that, as Deb
6 said, we are all professionals here. I think we understand
7 our role, and I think some of the things that are in -- some
8 of the language that's in there is really unnecessary, you
9 know. We are proactive. That's our role, but I think we
10 should just -- it just feels like a little bit of a lecture
11 that I think is really unnecessary. And as you said before,
12 we are all professionals. We are all aware of our role here.
13 We are aware of what the statute is. We've all been
14 incredibly briefed at every single meeting about what that is,
15 and I think we should avoid any language that appears to --
16 well, for example, we have heard public comment in every
17 single meeting, and the first thing we're talking about today
18 is a member of the Administration providing comment about our
19 role here. And I think that, if that person didn't believe
20 that we should issue a public report, then they could have
21 come and provided that public testimony, just like everybody
22 else. And it feels just a little bit heavy, first thing in
23 the morning, to be lectured about what our role and guiding
24 principles are, which are not what are in our -- what we
25 agreed to, as a Commission, and not what our statutory charge

1 is -- and then I just think it's a little bit heavy-handed
2 when we really need to be open to the process.

3 CHAIR HURLBURT: Bob and then Representative Keller?

4 COMMISSIONER URATA: I -- you know, I agree with some of
5 the points Val makes. I don't necessarily agree that's it's
6 heavy-handed though, but I know it's early in the morning.
7 And to me, I think these points are helpful because I'm a new
8 member and maybe I've not received this information as much,
9 and I thought it kind of turned on some lights in my head when
10 I first read it. I did not feel it was heavy-handed, but you
11 know, that's just my opinion. And rather than just focus on
12 this, let's move on.

13 COMMISSIONER KELLER: I concur, but what I just want to
14 point out, respectfully, is the Legislature reads the report.
15 This is incredibly valuable because we always get hit up from
16 so many different angles, and to be assured that this is not
17 an advocacy group for any particular thing, you know, and that
18 we have considered public testimony and then made our
19 professional -- you know, your professional recommendation, I
20 think it's a valuable slide. Thanks.

21 COMMISSIONER STINSON: Thank you, and I always appreciate
22 being reminded of important things. And with respect to the
23 comment that you shared with us earlier, objective does not
24 mean not asking for input. Objective means taking input,
25 including public comment, and then being objective in our

1 analysis of that and our decision whether or not to include
2 it. I think this description of us as influencers rather than
3 doers is helpful to me, and I would just add one thing under
4 "General Policy." I think, if we focus not only on the what
5 but the why, that that's also an important part of what we do,
6 you know, why is this important, why is this thing we're
7 describing important, and then move to the left. So thank
8 you.

9 COMMISSIONER CAMPBELL: Well, I -- there is one comment
10 here that almost made me turn down this appointment in the
11 initial thrust. That was, "Commission has no authority."

12 In almost 50 years of sitting around tables, like this,
13 in "the advisory capacity," I just hate that word because I've
14 been ignored. I've sat on lots of committees over the years,
15 and.....

16 COMMISSIONER ERICKSON: You hate the word "advisory?"

17 COMMISSIONER CAMPBELL: I have been ignored by the
18 bureaucrats because they were just using the committee as a
19 cover, and I had to -- well, I voiced, I think, to you early
20 on because I've just been on enough of these committees who
21 have been totally ignored and just used for political cover,
22 and I was afraid that that might be the case here, but I have
23 been greatly surprised.

24 COMMISSIONER ERICKSON: Moving on.....

25 CHAIR HURLBURT: Thank you, Deb.

1 COMMISSIONER ERICKSON: Yes. Did you have another
2 comment?

3 CHAIR HURLBURT: No. Go ahead.

4 COMMISSIONER ERICKSON: So just in terms of context
5 again, too -- and I know -- you know, I mean, the reason I put
6 this together -- because I know that there is a real tension
7 and frustration and that it was more important to talk about
8 it than to ignore it. And so I'm doing the same from the
9 perspective of context and what we've been focused on, that we
10 have been very focused, so far, on the cost of acute medical
11 care.

12 And again in the interest of trying to draw some
13 boundaries around the work of the Commission, so we didn't get
14 spread 50,000 miles wide and half-an-inch deep, that, while it
15 wasn't specifically stated, some of us, at least, believe that
16 the reason the Commission exists in the first place -- after
17 20 years of having a whole series of ad hoc groups, the reason
18 that we were established in statute this time is that the
19 concern over medical inflation got to the point where the
20 Legislature could bring themselves to form one more board or
21 commission, which I didn't know before we were formed how many
22 boards and commissions the State has. There are a lot.

23 Acute medical care, we've learned in our earlier work, is
24 the largest component of health spending. Approximately 70%
25 of all health spending, if not more, is for acute medical care

1 and that it's a significant proportion of state and federal --
2 a significant proportion of healthcare spending is dollars
3 from the state and federal government, and there is growing
4 concern -- I know we heard that, over a couple of
5 presentations that we had from Commissioner Hultberg over the
6 downward trend in projections for state revenues, and we
7 certainly know what's happening with the federal government
8 funding right now.

9 And so we have an opportunity, and in the 25 years that
10 I've been with state government -- and I remember in the mid-
11 '80s when the price of oil dropped to \$6 a barrel, and it
12 crashed. Our real estate market crashed with it, and lots of
13 other things went tumbling down.

14 When it comes to government spending for healthcare, when
15 there is that drastic of a fiscal crisis, the folks who always
16 get hurt the worst are the poor and vulnerable and -- because
17 the thing to do in a crisis is to slash benefits, to slash
18 eligibility, and you know, I don't know if it's too late, if
19 we have time, but I think we are focusing on strategies to
20 improve value and to try to address the cost problem through
21 bringing more value into the healthcare delivery system.

22 And then just in terms of context, the Affordable Care
23 Act is certainly the most significant federal legislation
24 affecting healthcare in nearly half-a-century.

25 So again, just to put out on the table for conversation

1 because I know that this is a tension enough and a
2 frustration, but to be real clear about it, that we've been --
3 another set of boundaries that we've been trying to draw
4 around our work is to stay focused on addressing the costs of
5 acute medical care. David?

6 COMMISSIONER MORGAN: I guess I haven't served on enough
7 boards and commissions. I've only served on three. Two of
8 those were on the municipal level. I didn't think it was
9 heavy-handed. It kind of gave me broad lines to try to temper
10 my over-enthusiasm, sometimes, to say and to do things.

11 I did -- and I did make a copy, in case anyone's
12 interested -- read all of the comments you've got, and I can
13 only say, especially from the State Hospital Association --
14 and several -- many of the comments that were very detailed,
15 and some of it as much as 20 and 30 pages, I thought were very
16 good and very helpful. I, personally -- as we say below the
17 Mason-Dixon, I've never smelled, touched, or heard anything
18 you can't talk about in a public setting. So I have no
19 problem with us putting documents out and letting people
20 comment on them. There were a few silly ones, but there were
21 a lot that helped me understand what's going on better. So I
22 mean, I thought they were important enough to print, so if
23 that's any consolation. And I thought Val's comments, her
24 letter was very helpful, I thought.

25 COMMISSIONER ERICKSON: And finally, just in terms of the

1 strategy we've been focusing on, I included this chart.....

2 UNIDENTIFIED FEMALE: Can you turn your mic on?

3 COMMISSIONER ERICKSON: Thank you. Sorry. Thank you.

4 In terms of context, I thought it was helpful to look at this
5 recent chart from the Institute of Medicine, the *Best Care at*
6 *Lower Cost* report that, in part, analyzed estimates of waste
7 in the healthcare system. And so they had identified, I
8 think, 30%, and we've heard different percentages over the
9 past couple of years, but 30% comes out most frequently. I've
10 heard anything between 20% and 50% of healthcare spending is
11 waste, that it's going for unnecessary or inefficient
12 services.

13 And so we could draw direct lines to several of the
14 pieces of this pie between the strategies that we've been
15 working on related to evidence-based medicine and trying to
16 make some improvements around the use of unnecessary services,
17 payment reform and how that might drive out some of the
18 efficiencies, ultimately, in care delivery -- that's the hope,
19 anyway -- studying pricing and variations and pricing between
20 Alaska and other states. So I thought it might be helpful,
21 again in terms of context, to look at this chart.

22 And the strategy pyramid that we put together, at one
23 point -- that I put together to try to capture in some sort of
24 graphic the main themes around the strategy that the
25 Commission was pursuing in terms of trying to drive increased

1 value in the healthcare system, improved access, and
2 ultimately, improved health, and our focus has been on looking
3 at what we could do to build and maintain a sustainable
4 foundation for the system, looking at some of the cross-
5 cutting issues in the healthcare delivery system and focusing
6 our policies, as much as possible, on giving consumers and
7 patients more of a role in their own healthcare and supporting
8 them to live healthier lifestyles. So I'm, again, just
9 providing some context as we go forward.

10 And this last slide in our little background discussion
11 is -- I thought you would be interested. We had a
12 presentation at, I think, it was our August meeting from
13 leaders of the Healthy Alaskans 2020 Initiative. And I had
14 circulated to all of you and also to our ListServ -- we're up
15 to nearly 900 people on our ListServ at this point, folks who
16 are interested in following our work and getting periodic
17 updates -- the link to the survey. And so the Advisory Team
18 and leadership for Healthy Alaskans circulated this survey to
19 get a sense of what the general public is interested in, and I
20 would encourage you, when you have time -- I didn't want to
21 kill too many more trees, so I didn't print it, but there is a
22 20-page Executive Summary of the results of the survey, and
23 it's available online on the Healthy Alaskans 2020 website,
24 but the areas most relevant -- first of all, the top ten
25 health concerns identified by the group that responded as well

1 as a couple of the areas where there were comments that were
2 most directly related to the work of the Commission so far, we
3 pulled into this slide, and I just thought you would be
4 interested in seeing that, since this isn't something that
5 we've done while we've opened up time at each of our quarterly
6 meetings during the year for public comment, public testimony,
7 and then also invited public comment. We haven't gone out
8 actively trying to gather information about what the Alaskans,
9 in general -- the general public is interested in and
10 concerned about when it comes to health and healthcare. So
11 just information.....

12 CHAIR HURLBURT: Did you mention that that reflected over
13 1,500 responses?

14 COMMISSIONER ERICKSON: Yeah. Ward, you're sitting with
15 your back to the slide. So it is -- it's up there.

16 CHAIR HURLBURT: Oh, we've got that.

17 COMMISSIONER ERICKSON: It's up there. It's up there.

18 CHAIR HURLBURT: Yeah, and there was a Gallup survey done
19 three to four weeks ago now nationally where the results were
20 very similar on the cost of healthcare, overweight and
21 obesity, and access were their top three for Gallup.

22 COMMISSIONER DAVIS: Was alcohol as high on that one?

23 CHAIR HURLBURT: Not as high in the Gallup poll.

24 COMMISSIONER ERICKSON: And this was a pretty
25 representative survey, geographically, too. It got even a

1 little bit higher percentage, I think, of rural Alaska than
2 the reflected.....

3 CHAIR HURLBURT: (Indiscernible - simultaneous speaking)

4 COMMISSIONER ERICKSON: It was -- yeah. Rural Alaska was
5 over-sampled. So any other comments about context before we
6 move on, questions?

7 Well, let's dive in. Just a couple of points, again,
8 about process here, as we're going to go through this during
9 the day today. I went ahead -- I took the liberty of making a
10 couple of changes in advance to the text of Findings and
11 Recommendation. A couple of them are suggested by Ward, and
12 he'll make a motion about those, related to changes to the
13 pharmaceutical findings and price findings and also the
14 proposed SNF study, which I explained to all over email as
15 well.

16 So in addition to those -- and it's just in the interest
17 of trying to facilitate and move us along. So if you want to
18 undo anything I've done -- anything where we got a comment
19 where it was real clear, the change that was being suggested
20 or recommended, and it didn't seem to affect, substantively,
21 the conversation that you had, if, for the most part, it just
22 added some clarifying information or rewording so the
23 statement was a little more clear, I went ahead and put those
24 in and am proposing it. And so we'll -- as we get to those --
25 but I just wanted to let you know that I tried not to put

1 anything in that changed, in any way substantively, the
2 concepts that were discussed by the group, and if any of you
3 think I crossed that line, please call me on it.

4 What we're going to do -- you have the summary table as
5 well as the complete body of the comments, and it's cross-
6 referenced with page numbers. If you want to stop and take
7 some time, if we're moving too fast, if you want to go back
8 and look at the actual body of the comments on anything in
9 particular that we're looking at, we will take time to do
10 that. I think we'll have plenty of time to do that. And I've
11 organized the conversation today, essentially, around the
12 structure of our Table of Contents. So we're basically just
13 going to be walking through the report.

14 What I'm going to do is just very briefly -- and I have
15 bullets related to these where I've just paraphrased. So
16 again, if anybody thinks that either in the summary table or
17 in a short bullet, that I've missed the point of one of the
18 comments that was being made, please take time to call me on
19 that, and we can go back and revisit it, too. I did my best
20 to capture the main points that I thought folks were trying to
21 make to the group here. So let's get started.

22 Well, first of all, I have a slide here -- and I'm on
23 slide 11 for folks who are on the phone. We received comments
24 around the vision and definition statements, which we weren't
25 -- and I guess another point that I want to make -- we -- it's

1 been a little bit of a challenge in putting out the draft
2 where we really are just inviting comments on Finding and
3 Recommendation statements and plans for the coming year, but
4 then to not provide more information about what the
5 Commission's process has been, our vision definitions, goals,
6 those sorts of things, prior year Findings and Recommendations
7 where, even to put the full body of those in would make the
8 document so long.

9 I've been trying to make sure that the folks who might be
10 reading this document or who are not familiar with or not
11 intimately engaged in following the work of the Commission
12 have enough context to understand all the other pieces and
13 that we're not ignoring these other pieces and have addressed
14 them in some way, but it's hard then for folks to not respond
15 to some of these other pieces and provide comment. So we
16 really weren't inviting comments on some of these other
17 things. That doesn't mean you can't address them today or put
18 it on the table for something that we make sure that we
19 address with a little more time for discussion and thought in
20 the coming year.

21 We did receive comments regarding our Vision Statement
22 and our definitions, a comment regarding our pharmaceutical
23 cost findings, comments regarding behavioral health care, our
24 2013 plans for studying the current system, telehealth
25 findings and recommendations, End-of-Life Care, employer's

1 role, and our 2013 agenda in terms of transformation
2 strategies that we'll be looking at. We also received a
3 number of comments regarding some of the areas of prior year
4 Findings and Recommendations as well, and those will all be
5 listed and discussed, but I didn't list them on this slide.

6 So starting with the more introductory piece with Vision
7 Statement and definitions, a couple of comments that it would
8 be nice to include the actual data for the three benchmarks
9 associated with our vision, and I do intend to do that. I
10 didn't have a chance to look those up and provide them on a
11 slide now, but plan to include that data in our actual 2012
12 report. A recommendation that we include a fourth benchmark
13 related to health disparities, and then regarding definitions,
14 that our definition of health and healing didn't address, as
15 clearly as the commenter would like to see, the importance of
16 mental health and freedom from addiction and that our
17 definition of the healthcare system omits other public
18 providers, API and Corrections. So does anybody.....

19 COMMISSIONER DAVIS: Page numbers refer to.....

20 COMMISSIONER ERICKSON: So the page numbers on the slide
21 refer to the page number in the packet of the actual body of
22 the public comment so if you want to take a minute to
23 reference that, and it's the little handwritten number in the
24 upper right-hand corner of each page.

25 (Pause - Commission members review document)

1 COMMISSIONER DAVIDSON: Deb?

2 COMMISSIONER ERICKSON: Yes, Val?

3 COMMISSIONER DAVIDSON: So you mentioned earlier that you
4 were going to include some data for what the three benchmarks
5 are. Can you just highlight what those might be? I know
6 that, in our earlier conversation, I had mentioned a concern
7 about number three, the lowest per capita healthcare spending
8 level, and I guess I was suggesting -- questioning how we
9 measure that. So for example, is it per capita as compared to
10 income or is it -- so can you elaborate a little bit on what
11 those data points would be?

12 COMMISSIONER ERICKSON: They would be just what's
13 specified here. So for the life expectancy, it would be the
14 life expectancy of Alaskans compared to -- or where we rank, I
15 guess, compared to the other states, where we rank in terms of
16 the percentage of our population with access to primary care
17 and where we rank relative to overall healthcare, per capita
18 healthcare spending.

19 COMMISSIONER DAVIDSON: And I guess the reason I had
20 asked about that third one is that businesses -- and
21 healthcare is no exception. Generally, the highest cost of
22 running a business is personnel. And I'm wondering how
23 reasonable it is to expect to have the lowest per capita
24 healthcare spending level, which ignores that Alaskans have
25 some of the highest costs of living than other states. So

1 this measurement, to me, makes sense, if you are comparing
2 that based on income. So for example, highest -- and I'm not
3 a math person, clearly. I'm not explaining this very well,
4 but if we were the lowest per capita healthcare spending level
5 as compared to average income of the average citizen, that, to
6 me, would make sense.

7 So for example, we're not necessarily going -- we could
8 accomplish this really easily, if we simply -- and I'm not
9 advocating for this, but if we simply renegotiated all of our
10 contracts and severed salaries in half, then I'm guessing that
11 the cost of healthcare, the cost per capita that people are
12 spending on healthcare can happen pretty darn quickly.

13 COMMISSIONER ERICKSON: Well, the point -- I think the
14 point is that the three come together in a package, kind of
15 like the Triple Aim that the Institute of Healthcare
16 Improvement puts out, that you have to make sure that you're
17 addressing all three at the same time, that it's not one over
18 the other.

19 COMMISSIONER DAVIDSON: I guess my point was, how were we
20 measure -- I'm trying to get to, how were we measuring that
21 third one?

22 COMMISSIONER ERICKSON: Pat and then Wes?

23 COMMISSIONER BRANCO: Just real quickly, I think you're
24 right on the money. It's a correlation between per capita
25 income and then per capita healthcare spending across the

1 nation. So tying those two together to make a reasonable
2 argument so we can do a side-by-side comparison is the right
3 answer.

4 COMMISSIONER KELLER: I would just add that -- a quick
5 read -- you know, considering that they're very broad, it
6 could be either. It doesn't matter. In other words, you
7 know, you could make an -- if we had to make a case whether we
8 were effective or not, surely, we would know if we were -- you
9 know, we would adjust the comparison for income. So I mean,
10 we don't want to get into that kind of detail. I think this
11 covers this concept.

12 COMMISSIONER ERICKSON: Colonel Harrell?

13 COMMISSIONER HARRELL: Right. So I would agree. I
14 think, in terms of a Vision Statement, if we tried to get too
15 far down in the weeds and too prescriptive in either of these,
16 it becomes a cumbersome document. So my commentary and vote
17 would be to leave the vision as it currently stands,
18 recognizing general principles and generally accepted
19 standards would be used in terms of determining this. Having
20 to prescribe becomes, to me, too burdensome.

21 COMMISSIONER ERICKSON: Jeff?

22 COMMISSIONER DAVIS: I just agree.

23 COMMISSIONER ERICKSON: So my plan right now, based on
24 the conversation without a motion to change the wording of
25 this third bullet, is to go with just the straight per capita

1 healthcare spending level without making that adjustment
2 that's being suggested and reporting it. I feel as though I
3 need a clarification of that third bullet and then a motion
4 needs to be made to do that or a request that we talk about it
5 and put it on our agenda for further conversation in the
6 coming year. Yes, Dr. Urata?

7 COMMISSIONER URATA: Is there a motion on the table?

8 COMMISSIONER ERICKSON: No. No.

9 COMMISSIONER URATA: So there is no motion, right?

10 COMMISSIONER ERICKSON: No.

11 COMMISSIONER URATA: So we could just move on.

12 COMMISSIONER HARRELL: Unless there is a motion to
13 change, there is no further business to be discussed.

14 COMMISSIONER ERICKSON: Any other questions, comments,
15 discussion, motion about any of the comments related to the
16 Vision Statement or definitions?

17 (Pause)

18 CHAIR HURLBURT: I think they're nodding, Deb.

19 COMMISSIONER ERICKSON: What's that?

20 CHAIR HURLBURT: I hear nods.

21 COMMISSIONER ERICKSON: I'm watching people read and
22 trying to allow enough silence and space for folks to speak
23 up.

24 CHAIR HURLBURT: Yeah. I think, where I do a lot of
25 talking about healthcare costs and make international

1 comparisons, on most of my slides now, what I get from the
2 literature, you have both, the things that Val mentioned. You
3 have the per capita dollar equivalent cost, and you have the
4 percent of your GDP and that's the cost reflected
5 (indiscernible - simultaneous speaking).

6 COMMISSIONER ERICKSON: Right. The reason I have pulled
7 in GDP is that, in different states, GDPs are measured in
8 different ways, and I haven't been able to find an economist
9 who feels comfortable enough saying yeah, this is a good
10 source of state GDP to use. So that's why I haven't used that
11 before or suggested it before in our report.

12 CHAIR HURLBURT: And I wasn't suggesting changing it, but
13 I just think that reflects, at least, what I heard Val saying;
14 is this compared to the realities of the.....

15 COMMISSIONER ERICKSON: Of the overall economy?

16 CHAIR HURLBURT: Yeah. And the answer is kind of yes.
17 Can we go on?

18 COMMISSIONER ERICKSON: Should we move on to Findings?
19 Okay. So related to the areas that we studied this year, just
20 to understand the current system better, we received a couple
21 of comments, but both from the same person, regarding our
22 pharmaceutical cost findings, a suggestion that Senator
23 Murkowski support a federal bill related to pharmaceuticals
24 and a point that Congress prohibits Medicare and Medicaid from
25 going out to bid for pharmaceuticals. There are some

1 suggested clarifying and contextual changes and additions that
2 have been made, based on some thoughts and verbal comments
3 that Ward had heard. So Ward is going to make a motion, in a
4 minute when we get to pharmaceutical costs, that you consider,
5 as a group, and have a conversation about the suggestions
6 there.

7 We didn't receive any comments at all on the other two
8 areas, government regulation and medical malpractice. So I
9 have suggested one edit to medical malpractice, again, based
10 on an oral comment that I received that was -- made it appear
11 as though the person didn't understand and it was poorly
12 written, the way it was written. So it was just a suggestion
13 to reword it, one of those finding statements, so it gets a
14 little more clear.

15 So let's go to the pharmaceutical price findings. You
16 want to.....

17 CHAIR HURLBURT: Okay. And.....

18 COMMISSIONER ERICKSON: And we're on slide 17, for folks
19 who are on the phone.

20 CHAIR HURLBURT: This is, basically, intended to clarify
21 the language, based on some responses that we had that came
22 actually from some of the pharmacies with some
23 misinterpretations of the information that had been provided.
24 So these changes were not intended to really change what had
25 been said and its intent, but just to clarify it. And so I

1 will make a motion to accept these wording changes that are
2 indicated there. Pat?

3 COMMISSIONER BRANCO: I would second, but I'd like to
4 move to discussion.

5 CHAIR HURLBURT: Please. Go ahead.

6 COMMISSIONER BRANCO: I just want to go back to the
7 previous slide on the three general comments about pharmacy,
8 pharmaceutical cost findings and that line about "Congress
9 prohibits Medicare and Medicaid from going out to bid." I
10 think it's in error. The 340B program is clearly one, while
11 it's not directly Medicare and Medicaid going out to bid, it's
12 certainly through the agents of Medicare and Medicaid that we
13 do go out to bid and contract with retail pharmacies to
14 provide that service. So we should stay clean on that one.

15 CHAIR HURLBURT: Yeah. When Deb and I discussed that, we
16 discussed that, but this reflected the public comment, but
17 yeah. My mind is exactly where yours is, Pat, on that. Yeah.

18 COMMISSIONER ERICKSON: Yeah. That is important to note.
19 Thank you.

20 CHAIR HURLBURT: Any comments or questions on page 17 on
21 the clarifying language? It's been moved and seconded. Oh,
22 Wes?

23 COMMISSIONER KELLER: This may -- I mean, this may not
24 work any time for sure, but the second bullet where it talks
25 about us being 17% higher, would it be of any value there to

1 include data? It would be just three or four sentences, you
2 know, that Workman's Comp pharmaceutical spending is "X"
3 percent of the total pharmaceutical spending? It just seems
4 like it would be helpful.

5 COMMISSIONER ERICKSON: So you're suggesting we add the
6 proportion of the volume, essentially, that the.....

7 COMMISSIONER KELLER: That the Workman's Comp -- yeah,
8 because the Workman's Comp is the highest in the nation, and I
9 think part of the reason, rightly or wrongly, that it hasn't
10 been dealt with -- I mean, I'm talking general, not just
11 pharmaceuticals -- is because it is such a small piece of the
12 package, and I don't know. That just seems like that might be
13 a clarifying.....

14 COMMISSIONER ERICKSON: Yeah. I'm trying to remember.
15 It was pretty small, like one percent or.....

16 COMMISSIONER URATA: Call for the question.

17 CHAIR HURLBURT: As stated here, as written, all those in
18 favor, aye.

19 COMMISSIONERS IN UNISON: Aye.

20 CHAIR HURLBURT: Opposed? No. It's unanimously carried,
21 Deb. Thank you.

22 COMMISSIONER ERICKSON: Sorry. It's taking me -- I went
23 ahead and put the body of all of our Findings and
24 Recommendation Statements into slides, just in case you all
25 decided you wanted to do something more with it. So I'm

1 paging ahead, and what I'm skipping is the body of those other
2 Findings and Recommendations.

3 And I am going to slide 23, and this is the one change
4 that I was going to suggest, that I'm suggesting. So someone
5 will need to make a motion, if you want to make this change
6 and second it and move it. And again, the intent -- this is
7 on the final -- I think this was the final bullet related to
8 our medical malpractice reform findings, and it was a long
9 sentence. And so I'm just suggesting breaking it into two
10 sentences and clarifying a little bit, so that it would read,

11 "Cost savings associated with defensive medicine
12 practices are more difficult to identify because there
13 are other contributors to these practices beyond the
14 threat of litigation. Other factors that may influence
15 defensive medicine practices include....."

16 And then the same list that was there. So it really is
17 just meant to clarify. Pat?

18 COMMISSIONER BRANCO: I'll make a motion to accept the
19 edits as written here.

20 COMMISSIONER HARRELL: Second.

21 CHAIR HURLBURT: Moved and seconded. Any discussion?
22 Call for the question.

23 COMMISSIONER BRANCO: I'm sorry. Who seconded?

24 COMMISSIONER ERICKSON: Colonel Harrell.

25 CHAIR HURLBURT: Colonel Harrell; yeah. All in favor of

1 accepting the wording breaking the two sentences say aye.

2 COMMISSIONERS IN UNISON: Aye.

3 CHAIR HURLBURT: Opposed? No. Unanimous.

4 COMMISSIONER ERICKSON: Thank you. Moving on, there were
5 a couple of other things related to our study of the current
6 system, and one I need to apologize for because the comments
7 were very valid, that we didn't address behavioral health
8 care. We didn't have findings, and we weren't going to have
9 findings related to the behavioral health care system without
10 more time to study, but we -- you all had wanted to learn more
11 about it. We had a very good presentation in March.

12 My apology -- I'm not going to share too much personal
13 information, but I think it's important for you guys to know
14 because you're my bosses that I have had a really very
15 challenging year in my personal life, and the night before the
16 meeting where we had this presentation in March -- you're
17 familiar with the list of the ten most stressful things that
18 can happen in your life. One of the top three things happened
19 the night before that meeting, and since then, two other
20 things on that list have happened to me, one, three or four
21 times. So work has actually been helpful. As challenging as
22 working on healthcare reform can be, it's kind of been an
23 oasis. But that is my apology for not having written that up.

24 I posted the audio recording of that session as soon as I
25 could, and it's there. And I will be writing that up and

1 running it by the folks who made the presentation to make sure
2 we capture that information. So it will be in our 2012
3 report, and I would have liked to included it, just to
4 acknowledge it and provide, at least, an outline of the
5 information, but it got too hard with the time we had
6 available. Pat?

7 COMMISSIONER BRANCO: Thanks for sharing that with us.
8 That's very helpful for all of us, and if Pat Branco's
9 comments are on the top 100 of that most stressful list, I
10 apologize as well if I've added stress to your life.

11 COMMISSIONER DAVIS: Top 15, Pat.

12 COMMISSIONER ERICKSON: Yes, Bob?

13 COMMISSIONER URATA: Yeah. I'd like to echo the
14 comments, but add that I know you are the most responsible,
15 loving, and hardworking person that I know here. Carry on.

16 COMMISSIONER ERICKSON: Thank you. Thank you. So let's
17 move on to our plans for next year, for study of the current
18 system, and I had explained -- Ward, maybe you want to just go
19 ahead and make the motion related to -- we had two things on
20 the list, cost of skilled nursing facility care and also
21 continuing work to track implementation of the Affordable Care
22 Act. And so Ward, do you have a motion you want to make
23 related to that?

24 CHAIR HURLBURT: Yeah. A little background. Our initial
25 plan, in looking at the cost of care, had been hospital care,

1 physician care, pharmacy, and SNF, and I was the driver on the
2 SNF, viewing it, in my experience, as a part of the spectrum
3 of acute care, and what's happened has kind of reminded me of
4 a bumper sticker that we used to see here, which basically
5 says, I don't care how they do it Outside. But I was kind of
6 a slow learner. I was kind of stubborn in continuing to push
7 this, but Pat and Karen Perdue and the Hospital Association
8 said, no. We really don't do it. And initially, Karen was
9 going to come over with some of her folks, and she told Deb --
10 she said, I don't know who to bring, other than our long-term
11 care people. And I said, well, that wasn't what I was
12 thinking. Well, I also met with Kim Poppe-Smart and Bill
13 Streur, and they said the same thing that Pat had been saying
14 and Karen Perdue, that the way we do it up here, that we
15 really can't separate it out, and it is a part of long-term
16 care and that had not been a part of the intent.

17 So while I may have been kind of stubborn, I'm not
18 totally stupid. If the Hospital Association and the
19 Commission and my boss are saying, it's not something we
20 really can or should do, then I will make the motion, which I
21 think is totally appropriate, that we eliminate this from our
22 plan for the coming year.

23 And as Pat and I were talking earlier, there may be a
24 different way that we would want to come back and look at this
25 spectrum, but we're not really ready to do that at this time.

1 So I would move that we do not plan to go ahead next year and
2 study the SNF costs. Pat?

3 COMMISSIONER BRANCO: I'll second that.

4 CHAIR HURLBURT: Thank you. Any discussion? All those
5 in favor of the motion to eliminate this plan for next year?

6 COMMISSIONERS IN UNISON: Aye.

7 CHAIR HURLBURT: Opposed, the same? That carries.

8 COMMISSIONER ERICKSON: Any other questions or discussion
9 or motions related to our plans for studying the current
10 system challenges for 2013? Pat?

11 COMMISSIONER BRANCO: I do have -- and I should have
12 submitted them earlier, but I have two suggestions for things
13 that we could, may, or should look at for the coming year, and
14 in particular, one has been driven by an email exchange. I
15 wish Allen was here. He and I have been having an ongoing
16 dialogue about his understanding of pricing, reimbursement, of
17 current health care, and I would imagine that there are not
18 many people in the room who understand it fully or the
19 relation between cost and price reimbursement systems, accrual
20 accounting versus cash accounting, which most people are
21 familiar with cash accounting. Perhaps we have a time when we
22 all elevate our learning and understanding. If we're ever
23 going to be in a position to recommend changes to an existing
24 system, we may need to educate ourselves on it's a very
25 complex world. So that's one.

1 Number two -- and it's for our own education. And much
2 like evidence-based medicine, to learn, as a group, before we
3 can discuss it well, we need to know what we're talking about,
4 and not to say Allen, but that's not Allen's world. That's
5 why we were having a really good dialogue on it.

6 My second one is on -- one of our charters is quality,
7 access and availability, the others. And I don't think we
8 spent a lot of time yet on quality, and I have one that we
9 ought to be looking at or I would recommend that we look at
10 more closely and that would be on value-based purchasing, and
11 one key component is readmission after 30 days, looking at
12 these rates across our state and actually trying to find a way
13 that we can help improve them because the other two elements,
14 access and availability, are one of the ways of addressing the
15 readmission rate and how we take better care of people when
16 they're inpatient, transfer to outpatient, and continue their
17 acute care episode into the next levels of care. Those are
18 two thoughts I've had for the coming year.

19 CHAIR HURLBURT: Should we just maybe list some of these?
20 I think -- Bob?

21 COMMISSIONER URATA: Yeah. I was thinking, from my point
22 of view, I'd like to have us look at the insurance system in
23 our state and possibly also add, you know, components of
24 Medicare and Medicaid to help compare the differences and how
25 they all work together in a healthcare system.

1 In terms of the insurance programs and with all due
2 respect to your program here in Alaska, Jeff -- or Mr. Davis,
3 you know, in the *Seattle Times*, there have been articles about
4 Regent having an extraordinary high amount of reserves, but of
5 course, their argument is that the Affordable Care Act is
6 coming and so they feel that they need to keep those high
7 reserves, but at the same time, their CEO gets, seemingly, a
8 large bonus. And so there are some things there that make me
9 question, you know, what's really the right way of doing
10 things.

11 CHAIR HURLBURT: We won't want to get too big a list, but
12 I don't want to put a damper on it. We will be, in our March
13 meeting, talking about the All-Payer Claims Database and that
14 will lead to some work, but there are some other things. I
15 think these are good suggestions. Val?

16 COMMISSIONER DAVIDSON: I think it would be helpful to
17 have a conversation. We've talked about behavioral health.
18 We've talked about telehealth. I think it would be
19 interesting to have a conversation about the state of oral
20 health in Alaska. I think that it's still the number one
21 reason that people are unavailable to be in active duty. I
22 know, in many of the smaller communities in Alaska, they have
23 rates of dental care, oral caries, dental caries of 7.5 times
24 the national average, and I think that exists here in
25 Anchorage as well, not that high, but we should probably take

1 a more focused look at oral health.

2 CHAIR HURLBURT: Jeff?

3 COMMISSIONER URATA: May I -- oh, go ahead.

4 COMMISSIONER DAVIS: Dr. Hurlburt, thank you. I was just
5 going to say, if it doesn't make the agenda, I'd be happy to
6 volunteer to do a Health Insurance 101 for anyone who is
7 interested, and you know, particularly deal with the reserve
8 issue and the salaries as a percent in total dollars issue and
9 that would be a lot of fun. Thank you.

10 No. The truth is a good thing to know, you know. When
11 you look at the whole thing, the picture, it makes sense.

12 COMMISSIONER URATA: (Indiscernible - simultaneous
13 speaking) very inflammatory article.

14 COMMISSIONER DAVIS: Well, we're the people people love
15 to hate, so you know, it makes good news. Thank you.

16 CHAIR HURLBURT: Yeah. I think that having us, as a
17 group and as individuals, understand that aspect would be
18 helpful to us, would be helpful to our state, and the industry
19 is getting beaten up on a lot nationally right now. So I
20 think that it would be important for us to get an
21 understanding of how it really does operate nationally, but
22 particularly here in Alaska. I thought that was a good
23 suggestion. Yeah?

24 COMMISSIONER BRANCO: And I think that goes hand-in-glove
25 with understanding healthcare reimbursement. Perhaps that's a

1 session where we combine this self-education of all of us
2 together.

3 COMMISSIONER ERICKSON: I want to get clarification on
4 the -- because -- and I don't even know that I wrote it the
5 same way that you described it, Dr. Urata, but I was imagining
6 you were suggesting we do something similar with the
7 comparison to cost in other states for the health insurance
8 costs, but that's -- Jeff is shaking his head. That's not
9 what you -- okay.

10 COMMISSIONER URATA: Just in this state.

11 COMMISSIONER ERICKSON: Just in the state?

12 COMMISSIONER URATA: Yeah. And I have something to add
13 to oral health. Can we have some comments specifically on
14 fluoride in the water or is that too controversial? That used
15 to be a good public health solution.

16 CHAIR HURLBURT: Yeah. One of our charges is prevention.
17 It's one of the five top priorities of the vision of public
18 health, one of CDC's ten most notable public health advances
19 of the last whatever -- how many years.

20 COMMISSIONER URATA: I'm specifically pointing towards
21 the movement to get rid of fluoride in public water.

22 CHAIR HURLBURT: David?

23 COMMISSIONER MORGAN: Well, I don't know if this helps
24 any. It probably doesn't. We're about to enter, just like
25 Juneau did, a major confrontation over this on a municipal

1 level in Anchorage.

2 What I found interesting is the individuals that have
3 brought this up took it to the Public Safety Commission and
4 not to the Municipal Health Commission. We're meeting --
5 we're trying to schedule a meeting now with the Mayor and the
6 Assembly to say we'll -- you know, we didn't think this was in
7 the same list of problems of how many police officers there
8 are.

9 I think what you find is, in my experience -- and I've
10 worked as a Health Administrator in the rural part of the
11 state for several years and as a City Manager for some small
12 communities -- that these individuals bring this up
13 constantly, but I did note in my message to the Mayor and the
14 Assembly Chair along with Dr. Kadell (ph) and several members
15 of the Commission, including a physician and a dentist, that
16 we thought it was a little bizarre that this went to -- did
17 not come to the Municipal Health. And if nothing else, we
18 should schedule that around lunch, so we can have a lunch and
19 a show. Why don't we go through that during public hearings?
20 Because anyone that's ever sat through these -- and Val is
21 going, like, oh my God, you know. Anyone that has sat through
22 this, there are some of the most bizarre arguments I have ever
23 heard, and if nothing else, to see the physicians and public
24 health officials levitate during that would be pretty
25 interesting, too. So yeah; I don't have a problem with doing

1 it, but be prepared.

2 CHAIR HURLBURT: I wonder -- we've had several areas -- I
3 think your thing is still on, David. We've had several areas
4 that we've not really taken on as a major focus and study, but
5 we have had folks come in, either an individual or a panel,
6 and educate us about -- and following on what you just
7 suggested, David, is this, where you're saying maybe is this
8 something we should look for, sometime during the year, just
9 to become educated about the issue.

10 COMMISSIONER MORGAN: Yeah, and I'm sure that the State
11 Dental Association and the Public Health Association will come
12 and give us a presentation, then have a public hearing, but
13 when you get into these arguments -- and I'm sure everybody is
14 looking at me going, oh yeah -- we'll all have to -- I mean,
15 we should listen, but the science is just irrefutable, from
16 what I've seen statistically. I'll leave to the Dental
17 Association or Medical Association to give comment and Public
18 Health on the public health impact, but wow.

19 CHAIR HURLBURT: Jim?

20 COMMISSIONER PUCKETT: Well, I certainly don't want to
21 diminish the challenge that we have in oral health. I've
22 spent plenty of time in villages and have seen the tragedy of
23 those that have not had dental care and they're losing their
24 teeth and so forth, but I'm just looking at what the
25 Commission is considering for 2013. We can certainly leave

1 oral health up there, and you know, dental services.

2 I just kind of wonder if we might want to just leave the
3 water fluoridation off because I think it might be a
4 distraction for some of the very things that we're discussing
5 here. I've seen some of those discussions, and I'm, like, I
6 don't know if we want to spend our time and staff, but we do
7 certainly want to bring up oral health and dental services and
8 begin gathering information. I'm just thinking from a -- just
9 from the distraction part of it, maybe we could just leave
10 those last two words off of that thing for right now. It's
11 probably going to come up in the education part that we go
12 through this, this next year, but if we put it out there, it's
13 going to be a lightning rod.

14 COMMISSIONER URATA: So I'll withdraw my question about
15 fluoride. I was part of the group that lost. You know,
16 despite me being on TV and writing editorials and stuff like
17 that, we still lost. It's incredible.

18 (Pause - background discussion)

19 CHAIR HURLBURT: Anything else?

20 COMMISSIONER ERICKSON: So we have added to our list for
21 study in 2013, but I'm just going to read this off and then
22 entertain a motion: cost of health insurance in Alaska,
23 especially addressing the reserve question, the medical loss
24 ratio, and the components of the cost of health insurance; a
25 second bullet about health care accounting and pricing and how

1 that works; a third bullet on studying hospital readmission
2 rates in Alaska; and a fourth that we'll spend some time
3 learning about oral health and dental services.

4 CHAIR HURLBURT: Where do you see All-Payer Claims
5 Database?

6 COMMISSIONER ERICKSON: It's actually in our strategies
7 section. This is just studying what we currently have. Does
8 somebody want to make a motion to add these?

9 CHAIR HURLBURT: What's your sense as far as the
10 magnitude of this list, the items there, and the feasibility
11 with four regular meetings, that that will fit in, are you
12 comfortable, Deb?

13 COMMISSIONER ERICKSON: Yes.

14 COMMISSIONER CAMPBELL: So moved.

15 CHAIR HURLBURT: Is there a second?

16 COMMISSIONER URATA: Second.

17 CHAIR HURLBURT: Any discussion? All in favor say aye.

18 COMMISSIONERS IN UNISON: Aye.

19 CHAIR HURLBURT: Opposed, no. Okay. Thank you. Good
20 suggestions.

21 UNIDENTIFIED MALE: (Indiscernible - away from mic) the
22 motion then? Sorry.

23 COMMISSIONER ERICKSON: Keith Campbell made the motion,
24 and Dr. Urata seconded it.

25 So moving on then to the section of the report where we

1 have some actual recommendations on health care system
2 transformation strategies. And starting with the first area
3 listed in our report, telehealth, we received a number of
4 positive comments from folks who appreciated that we looked at
5 telehealth, a suggestion that we make sure it's clear that we
6 see telehealth as complementing the current system, not
7 replacing healthcare delivery in rural Alaska, a comment
8 specific to our second recommendation that Alaska eHealth
9 Network can't take an additional role on right now -- and I
10 have a suggestion later on specifically related to clarifying
11 that recommendation related to that comment -- a comment that
12 the current reimbursement structure limits access to
13 behavioral health through telehealth technologies, that the
14 use of telemedicine increases problems -- that, as use of
15 telemedicine increase, problems should be monitored and
16 providers properly trained, that telehealth -- a specific
17 comment related to a point and a question about telehealth
18 licensure for physicians, a comment from the Nurses
19 Association that they have not experienced this as a
20 particular problem for nurses, continued investigation of
21 reimbursement and licensure issues, a suggestion that we
22 continue that, the State, not necessarily the Commission, and
23 I have just a couple of really, really minor changes to
24 improve grammar in a couple of the statements. Those are
25 comments from me, not from the public. Yes, Dr. Urata?

1 COMMISSIONER URATA: Are there still problems with
2 licensures for out of state physicians who are specialists or
3 is that on the way to being resolved?

4 COMMISSIONER ERICKSON: I think we've just suggested that
5 that needs to be understood better. So any questions before
6 we go to some specific changes? So on slide 28, I just
7 decided that those two sentences were a little awkwardly
8 worded, so I just suggested adding a comma and the word
9 "which" into both of those statements under "opportunities
10 exist" in our findings. And we've lost our English teacher.
11 Linda Hall had been an English teacher in a former life, and
12 she was helpful in this way. I don't know that this is the
13 best way to reword it or not, but she -- yeah. And I don't
14 know that we need to even make a motion for something this
15 simple. Does anybody have a suggestion for making it better?
16 Okay. Accepted.

17 Let's move on then. So recommendation number two on
18 slide 29 was -- the way it currently reads, "The Alaska Health
19 Care Commission recommends the Department of Health & Social
20 Services direct the Statewide Health Information Exchange
21 Entity to perform a business use analysis for offering a
22 statewide brokered telehealth service."

23 One of the things -- so just as a reminder and for folks
24 who maybe weren't there, at least folks in the room and the
25 public, the Commission had a series of recommendations -- or a

1 series of presentations -- I'm sorry -- at our June meeting on
2 current telehealth systems and initiatives around the state,
3 and two of the leaders in this arena, the Department of Health
4 & Social Services' Health Information Technology Coordinator,
5 Paul Cartland, and Dr. Stewart Ferguson, who is -- he is the
6 Chief Information Officer now for ANTHC -- isn't he, Val? --
7 and also the President of the American Telemedicine
8 Association. So they had offered, to all of you, that they
9 would come up with a suggestion, and this was the suggestion
10 that they came up with. And it's something that I actually
11 spent some time talking with Paul and Commissioner Streur
12 about to see how they would suggest moving forward, if we were
13 going to get, essentially, what we wanted.

14 And so a clarifying point. I think the commenter, the
15 person who offered the comment about AeHN, was concerned that
16 they have a lot on their plate right now, but this
17 recommendation actually isn't too AeHN, and we were finessing
18 something here. Essentially, what it was saying -- so let me
19 back up.

20 The legislative bill, the law that creates the Statewide
21 Health Information Exchange designates the State Department of
22 Health & Social Services as the Statewide Health Information
23 Exchange entity, and the Department then has a partnership
24 relationship and contracts with AeHN to develop and administer
25 the Health Information Exchange.

1 Essentially, what we were doing was recommending that the
2 Commissioner direct his staff person, Paul Cartland, to work
3 with AeHN -- so Paul is Contract Administrator for the AeHN
4 contract -- and to figure out the most appropriate way to see
5 that this study gets developed.

6 And to the point, I think one of the things that he
7 suggested, too, when I told him that there was some confusion
8 and concern about this, was that -- it actually was a
9 suggestion that Stewart had made, understanding that there
10 were opportunities for synergy between a Health Information
11 Exchange and this sort of telehealth service, that there
12 already was going to be a statewide system set up and
13 opportunities for kind of killing two birds with one stone.

14 To the point about whether AeHN already has enough on
15 their plate -- and this is getting probably too operational
16 for us, but one of the challenges that they face is
17 sustainability and being able to bring in enough revenue to
18 run the information exchange. So it's one of the things that
19 they're addressing right now in their continuing planning
20 efforts as they, at the same time, are trying to stand this
21 new system up. So one of the thoughts, I believe, if I can
22 speak for them, that Paul and Stewart had was that this,
23 potentially, could be a revenue generator for the Health
24 Information Exchange, but that's the sort of thing that a
25 business use analysis would investigate.

1 So I thought it would be helpful, rather than, in
2 essence, suggesting that Commissioner Streur direct Paul to do
3 this, that we reword this a bit and also for clarification for
4 folks who don't understand that the Department actually is the
5 Statewide Health Information Exchange entity, that we just
6 recommend that the Statewide Health Information Exchange
7 entity do it and then put, in parentheses, the Department of
8 Health & Social Services. Sorry. That was kind of a long,
9 convoluted explanation; did that make sense? Yep, Bob?

10 COMMISSIONER URATA: Question, isn't telehealth, as
11 described by the testimony we heard, different than health
12 exchange, two separate businesses, isn't it?

13 COMMISSIONER ERICKSON: Yes.

14 COMMISSIONER URATA: So I don't understand how one could
15 take care of the other.....

16 COMMISSIONER ERICKSON: This is a -- the suggestion.....

17 COMMISSIONER URATA:if they're struggling.....

18 COMMISSIONER ERICKSON:is to create a brokerage
19 service that would maintain directories, which the Health
20 Information Exchange will already have and will help enable
21 some -- and provide some sort of system for connecting folks
22 together. Right. Any other questions or comments?

23 COMMISSIONER MORGAN: I thought I saw a regulation or a
24 proposed regulation come out.

25 COMMISSIONER ERICKSON: The Department released

1 regulations for the Health Information Exchange just.....

2 COMMISSIONER MORGAN: And actually.....

3 COMMISSIONER ERICKSON:a couple of weeks ago, I
4 think.

5 COMMISSIONER MORGAN: Yeah, but wasn't it, like, setting
6 up a board or something or a commission, like, you know, going
7 into what their board make up is and stuff like that? I
8 didn't bring it with me.

9 COMMISSIONER ERICKSON: I didn't read them. Sorry.

10 COMMISSIONER MORGAN: We review everything and see if
11 we're going to answer them, but maybe, when we break, we can
12 go and get them, just to look at, but I remember, when I
13 scanned them, it went into some of what you're talking about,
14 but also defining their board, like having certain reps, sort
15 of like the Commission, having representatives on their board
16 from certain parts of the industry. And as I remember the
17 discussion, we saw synergy in that they basically would use
18 the same information highway type stuff, which would create
19 revenue possible streams for both, so you wouldn't have two
20 competing activities. That's the way I remember it is that --
21 have I got it?

22 COMMISSIONER ERICKSON: Yes, Val and then Jim?

23 COMMISSIONER DAVIDSON: I would move to approve the edits
24 as written on the PowerPoint.

25 CHAIR HURLBURT: Is there a second?

1 COMMISSIONER URATA: Second.

2 CHAIR HURLBURT: Seconded by Dr. Urata. Jim?

3 COMMISSIONER PUCKETT: I'm not opposed to the motion to
4 accept the edits, but I wanted clarification, if I could do
5 that, as the motion has already been made.

6 CHAIR HURLBURT: Please go ahead.

7 COMMISSIONER PUCKETT: I -- as someone who worked in a
8 division that had a couple of disparate topics, such as
9 retirement and then health benefits, and how you can put those
10 together (indiscernible - voice lowered). Sometimes, I've
11 really wondered that many times.

12 I do wonder a little bit about the Health Information
13 Exchange having such a different mission than telehealth. I
14 can see the connection that the Health Information Exchange,
15 obviously, it could involve the network connections and things
16 of that nature, but I do struggle a little bit with they are
17 going two different directions. They're providing two
18 different services there, and is that really the proper place
19 to have a brokerage in telehealth?

20 I was just wondering if, based on your conversation, did
21 you guys discuss that part of it, and how they may have to
22 deal with that organizationally?

23 COMMISSIONER ERICKSON: Yes, and I do not know if they've
24 talked directly with the leader of -- you know, the director
25 of AeHN or their board, but where they felt that there was a

1 lot of synergy in the actual functions that they would be
2 implementing as a Health information Exchange, what they're
3 suggesting here again is not -- they're not going to be
4 delivering a healthcare service. It's trying to facilitate
5 systems for the clinicians, and the Health Information
6 Exchange is going to have to establish, essentially, a
7 provider directory already and will have some of the similar
8 technological systems in place that they could kind of use as
9 the backbone for the information sharing service that we're
10 suggesting in this recommendation.

11 So I guess the service that they might be delivering
12 would be different, but I think, functionally, my sense is
13 it's not too different. It's -- they're providing a platform
14 for sharing information -- for maintaining information about
15 providers and sharing that information. Yes, Pat?

16 COMMISSIONER BRANCO: I was just going to add that the
17 last two bullets are where they tie together. Yeah.

18 COMMISSIONER ERICKSON: Allen?

19 CHAIR HURLBURT: Yes, Allen?

20 COMMISSIONER HIPPLER: Thank you. First of all, I am
21 very excited about opportunities to increase the market
22 penetration, if you will, of telehealth in the state of
23 Alaska. That being said, I'm a little concerned that we're
24 asking the State to develop a business use analysis. When we
25 do that kind of thing, we end up with the Matanuska Dairy Farm

1 or the barley farms or the ore terminal or ASMI, or in today's
2 parlance, film tax credits. We end up with all sorts of
3 stuff. I would much prefer a direction of telehealth is
4 already being offered. It's already there by private -- well,
5 if you can call it private -- industries and businesses, most
6 notably ANTHC.

7 I would prefer the State work with those private
8 providers to see how those private providers can expand their
9 services and open it up to other people. For example, ACS has
10 an existing network that GCI uses. I think we can all kind of
11 understand that. GCI doesn't have its own phone lines. It
12 borrows ACS'. Now that doesn't work 100% well for ACS all the
13 time, but it's something that -- it's a model that I would
14 prefer us looking at as opposed to the State developing a
15 business use analysis. Thank you.

16 CHAIR HURLBURT: So let me see if I understand. What
17 you're suggesting is that it is appropriate to look at the
18 value and to make a recommendation as far as suggesting that a
19 broker function be developed, but you're suggesting that we
20 should not assume that that be a government function, one, and
21 two, you're expressing your perspective that it probably would
22 be better being a private sector function; is that correct,
23 Allen?

24 COMMISSIONER HIPPLER: Yes. You are much more eloquent
25 than I am. Thank you. I'm simply not sure how to word that

1 as an amendment. If anybody does agree with me, I would be
2 willing to support it.

3 CHAIR HURLBURT: I guess we probably need some suggested
4 wording to have a vote.

5 COMMISSIONER ERICKSON: Well, and I'm wondering -- Allen,
6 were you more comfortable with the original wording?

7 COMMISSIONER HIPPLER: Yes. Well, to -- I like the more
8 general "Department of Health & Social Services" as opposed to
9 the "Health Information Exchange entity," and I would rather
10 instead of "to develop a business use analysis" just say
11 something like "work with existing providers to identify
12 opportunities for regulatory reform and cooperation between
13 users."

14 COMMISSIONER DAVIDSON: I think the maker of the motion
15 would not consider that a friendly amendment.

16 COMMISSIONER ERICKSON: Okay. And then we need
17 procedural help. So Allen, if you -- it's probably time for a
18 break anyway. If you wanted to reword a motion to make an
19 amendment to the motion and then we would vote on that? Is
20 that right, Val, we would vote on the amendment to the motion?
21 And then vote on the final motion.

22 So let's take a break for 15 minutes. It's quarter until
23 ten. Let's plan to be back at ten and see if we can help
24 Allen word a motion.

25 9:44:24

1 (Off record)

2 (On record)

3 10:00:26

4 CHAIR HURLBURT: Can we come back together, please?

5 (Pause - group reassembles)

6 CHAIR HURLBURT: Let me describe where I think we are,
7 and I'm open to a friendly amendment, if I'm not clear. We're
8 on page 29, number two, and this is the statement regarding
9 development of a brokerage type function related to telehealth
10 services. So we have the wording as modified on page 29,
11 attempting to provide clarification of the role of the State
12 vis-a-vis AeHN there, and we have an amendment by Val,
13 seconded by Bob to accept that wording. We then have an
14 amendment by Allen, which we have some wording on now, I
15 believe, and this is where I need guidance -- maybe from you,
16 Val -- to make sure I'm correct on this.

17 COMMISSIONER HIPPLER: There has been no official motion
18 of amendment yet; however, I would submit and I would ask for
19 your feedback. I think the best way to go here is to split
20 the question. Let's address the Department versus Information
21 Exchange question first and just get that out of the way
22 because that was an issue that was hanging out there.

23 CHAIR HURLBURT: Well, we still have a motion, I believe,
24 to accept this wording and then there may be what would be
25 posed as a friendly amendment, which may or may not be

1 accepted by Val as a friendly amendment. If it was not
2 accepted by Val, then we would vote on the motion that Val
3 made and Bob seconded up or down. If that was defeated, there
4 would then be the opportunity to bring up the change, unless
5 it was accepted as a friendly amendment. Val, correct me,
6 please.

7 COMMISSIONER DAVIDSON: Let's just call it friendly.

8 CHAIR HURLBURT: Okay.

9 COMMISSIONER ERICKSON: So -- the second part is friendly
10 because -- my understanding, from Allen -- and I have this in
11 two different slides; I've copied it. So in the sidebar
12 conversation, we divided it into two separate issues, the
13 clarification and question about the State HIE versus the
14 Department -- as the Department, whatever that means. And
15 then the second part, to get at the issue of what the service
16 was doing and who was actually doing it, was to add the words
17 "private sector" in front of "statewide brokered telehealth
18 service," just for clarification that this is not something
19 the Commission is suggesting, but that the government actually
20 offer as a service. So is that -- had you seen that, Val?
21 Because you weren't part of that conversation, would you
22 accept that part as a friendly amendment, the addition of
23 "private sector?"

24 COMMISSIONER DAVIDSON: I considered the language there
25 as written to be -- I'm not opposed to that language, so I

1 would consider it a friendly amendment.

2 COMMISSIONER ERICKSON: So with the addition of "private
3 sector," but leaving the first part the same. So then Allen,
4 if you wanted to suggest an amendment to what we have here now
5 with the addition of the words "private sector" to change that
6 first part of the recommendation statement back to the way it
7 was originally worded was what I understood would make you
8 feel comfortable. Is that something you want to suggest as an
9 amendment to the motion?

10 COMMISSIONER HIPPLER: It's more because I don't
11 understand it. It is conceivable that maybe some open
12 discussion would just resolve that issue, but based on my very
13 tenuous understanding of Department of Health & Social
14 Services versus the State Health Information Exchange, I don't
15 understand the change.

16 COMMISSIONER ERICKSON: So we could just have a
17 conversation about that as part of the discussion around the
18 standing motion.

19 COMMISSIONER URATA: So you can just do a clarification,
20 you know (indiscernible - away from mic) to clarify.....

21 COMMISSIONER ERICKSON: You have to turn on your mic.

22 COMMISSIONER URATA: Perhaps just a clarification of what
23 exists now compared to what existed before would be helpful
24 and all that's required.

25 CHAIR HURLBURT: So is the wording that's up there now

1 consistent with what you would like to introduce as an
2 amendment?

3 COMMISSIONER HIPPLER: Yes, Mr. Chairman.

4 CHAIR HURLBURT: Is there a second?

5 COMMISSIONER ERICKSON: I'm sorry. We were referring to
6 the wording that's up there now. The changes that are
7 documented here with the strikethroughs and the underlines,
8 Val already made a motion that that's -- that we make this
9 change. So I'm not sure what.....

10 CHAIR HURLBURT: Now there is an amended motion.....

11 COMMISSIONER ERICKSON: To change it back?

12 COMMISSIONER HIPPLER: No. To add "private sector."

13 COMMISSIONER ERICKSON: We already accepted that.

14 COMMISSIONER URATA: So you don't have to vote on that.

15 COMMISSIONER ERICKSON: Yeah. So what we're considering
16 now is, as it appears on the screen, which are all of the
17 changes, the deletion of "Department of Health & Social
18 Services" first, so that it reads "The Alaska Health Care
19 Commission recommends the Statewide Health Information
20 Exchange entity (the Department of Health & Social Services)
21 develop a business use analysis for offering a private sector
22 statewide brokered telehealth service, including" and then the
23 bulleted list. So that's -- the motion to accept that is
24 what's currently on the table.

25 CHAIR HURLBURT: And that's acceptable to you, as your

1 amended motion? So now discussion?

2 COMMISSIONER HIPPLER: I still have the general question
3 as to why we're leaving the -- why we're not asking a bigger
4 department to handle this as opposed to a specific Health
5 Information Exchange entity. Thank you.

6 CHAIR HURLBURT: Anybody want to address that, other than
7 Deb? Can you go ahead, Deb?

8 COMMISSIONER ERICKSON: Yeah. Well, the Statewide Health
9 Information Exchange entity is the Department. And I believe
10 the reason we're specifying the Statewide Health Information
11 Exchange entity rather than just saying we want the Department
12 to do this is to provide some direction that specifically the
13 -- well, based on what we understand of the Health Information
14 Exchange and this brokered service is that the Health
15 Information Exchange is what we're suggesting be considered
16 for providing the service. I'm making it worse. Val?

17 COMMISSIONER DAVIDSON: So would you be more comfortable,
18 Allen, if we deleted the "Department of Health & Social
19 Services," the parenthetical, if it just said, "recommends the
20 Statewide Health Information Exchange entity develop a
21 business use analysis for offering a private sector statewide
22 brokered telehealth service including?"

23 COMMISSIONER HARRELL: Sounds like the contrary. He
24 wants it actually raised up (indiscernible - away from mic).

25 COMMISSIONER HIPPLER: I don't see why we can't choose

1 one or the other. I'm very confused, and I'm sorry, Val. I
2 don't even know how to intelligently answer your question
3 because I don't understand the underlying basis as to the
4 difference between these two entities and why we would direct
5 one more specifically than the other or that is to say -- I'll
6 just stop talking. I don't know. I don't understand.

7 COMMISSIONER DAVIDSON: You are where I was this morning,
8 so I feel you, man.

9 COMMISSIONER URATA: Can I take a stab at trying to
10 explain this? So my understanding is the Department of Health
11 & Social Services is the big area and under them or within
12 them is the Statewide Health Information Exchange. So the
13 suggestion is, rather than going to the big thing, become more
14 specific and go to the specific area that would actually work
15 with this, and I think that's what we've changed.

16 Now if we just include the way it originally said with
17 the Department of Health & Social Service direct a Statewide
18 Health Information Exchange, then it would become more wordy,
19 if you will, and we're just crossing out the redundancy. Is
20 that the reason why you crossed out "Department of Health &
21 Social Services?"

22 COMMISSIONER ERICKSON: Well, I crossed it out and added
23 the Department of Health & Social Services in parentheses to
24 clarify for folks who might assume that the Statewide Health
25 Information Exchange entity is the other non-profit, but

1 that's not.....

2 COMMISSIONER URATA: So if we just leave it the way it
3 originally was, so it would read "recommends the Department of
4 Health & Social Services to develop a business use analysis
5 for offering a private sector," then you, as the Department of
6 Health & Social Services, would, most likely, direct it to the
7 Statewide Health Information Exchange; is that correct?
8 Because you guys are the Department of Health & Social
9 Services, so to speak. Is that correct? So it would go to
10 your division, and your division would probably just say, go
11 to Statewide Health Information Exchange or would it go to the
12 Commissioner and the Commissioner might.....

13 COMMISSIONER ERICKSON: Well, it would go to the
14 Commissioner, and the Commissioner would decide what to do
15 with it.

16 COMMISSIONER URATA: Yeah, and.....

17 COMMISSIONER DAVIS: That's the hierarchy.

18 COMMISSIONER URATA:at your advice, he would say,
19 go to the Statewide Health Information Exchange; is that
20 right?

21 COMMISSIONER ERICKSON: Are we losing -- or would we.....

22 COMMISSIONER URATA: So you're just becoming more
23 efficient in your wording.

24 COMMISSIONER ERICKSON: Would we lose an important part
25 of the recommendation though to not make the link for the

1 Commissioner to the Health Information Exchange entity? I
2 mean, we don't have to refer to the actual Statewide Health
3 Information Exchange entity. We could take out the words
4 "statewide" and "entity" and say we recommend that the
5 Department of Health & Social Services.....

6 COMMISSIONER URATA: Well, it.....

7 COMMISSIONER ERICKSON:develop a business use
8 analysis for offering a private statewide.....

9 COMMISSIONER URATA: So right now, we're just focusing on
10 where it goes to first. It goes to either the Commissioner or
11 it goes directly to you, and if it goes to the Commissioner,
12 he might have a different idea of what to do with it and then
13 we might lose it. Is that correct? Is that why we're going
14 directly to you folks? Or statewide health.....

15 CHAIR HURLBURT: AeHN reports to the Commissioner. So if
16 it went to him -- but maybe let me ask a question. If our
17 intent is that we see it as a desirable thing to look at a
18 brokerage function for telehealth services, do we really care
19 whether it goes to AeHN or not? Now I think, if the
20 Commissioner gets it, that's where he is going to send it
21 because they do that, but if he wants to send it to somebody
22 else and he thinks it will get done there, so what?

23 COMMISSIONER URATA: But you folks feel that it should go
24 to the Statewide Health Information Exchange. That would be
25 the best entity.

1 COMMISSIONER ERICKSON: Well, that's what you guys want.

2 COMMISSIONER URATA: Well, we don't understand what
3 Statewide Health.....

4 COMMISSIONER HIPPLER: Let me clarify. We're supposed to
5 look from the 50,000-foot level as opposed to 50-foot level.
6 We were reminded of that just the other day. Well, the
7 Department is the bigger level than the Health Network. Let's
8 just say we recommend the Department do this.

9 COMMISSIONER DAVIS: I agree.

10 CHAIR HURLBURT: Val?

11 COMMISSIONER DAVIDSON: I just want to make sure that
12 we're not going to hire another consultant, and I would really
13 -- you know, we've spent a lot of money on consultants, based
14 upon our recommendations, and I just think we should be
15 careful. I would prefer having the Statewide Health
16 Information Exchange entity do that business use analysis
17 rather than hire another consultant to carry out or work,
18 which those folks are perfectly capable of doing.

19 COMMISSIONER ERICKSON: Jeff?

20 COMMISSIONER DAVIS: I'll try to cautiously wade into
21 this morass. So I think, if we're start at 50,000 feet, it's
22 the Department's responsibility that AeHN functions under the
23 direction of the Department. So start with the Department of
24 Health and then, you know, work from there, direct the
25 Department to -- or recommend that the Department develop

1 this. And then I understand your point, Val, about another
2 consultant, but I think, you know, the Commissioner -- Streur
3 or whomever it is in that role -- is going to make the
4 decision as to where it's most appropriate. So let's use
5 Ockham's razor. Let's not through that in, if it complicates
6 things. I think keep it as simple as possible, you know, and
7 just make the recommendation to the Department, and most
8 likely, the Commissioner will say, have I got a job for you,
9 AeHN and that would be the outcome, but that's my
10 recommendation.

11 COMMISSIONER URATA: Can that be a friendly amendment,
12 too?

13 COMMISSIONER ERICKSON: It's up to Val.

14 COMMISSIONER DAVIDSON: At this point, just God Bless
15 America.

16 COMMISSIONER URATA: You're in charge, Val.

17 COMMISSIONER DAVIDSON: It doesn't -- sure. It's fine
18 with me.

19 COMMISSIONER URATA: So can you retype that to make it
20 the final draft by eliminating some of the crosses out?

21 COMMISSIONER ERICKSON: So you can read it?

22 COMMISSIONER URATA: Yeah.

23 COMMISSIONER ERICKSON: So what we're suggesting, at this
24 point, is eliminating "direct the Statewide Health Information
25 Exchange." So it reads, "The Alaska Health Care Commission

1 recommends the Department of Health & Social Services develop
2 a business use analysis for" -- I wonder if we should take the
3 word out, offering -- "a private sector statewide brokered
4 telehealth service."

5 COMMISSIONER HIPPLER: Yes.

6 COMMISSIONER ERICKSON: So the way it would read.....

7 COMMISSIONER HARRELL: So while she's typing -- so this
8 is another one of those times where I don't have a dog in the
9 hunt so I'm going to ask a question, just for discussion,
10 while she's typing.

11 What is the propensity of the State to resort to a
12 consultant? What is the current environment? Because,
13 despite the fact that I like brevity -- although you'd never
14 know that from I'm doing right now -- Val has a very good
15 point in terms of the propensity of folks to resort to
16 consultants of private sector, which spends an awful lot of
17 money, and I can say that because I'm a member of the United
18 States government.

19 CHAIR HURLBURT: You know, we discussed some with Bob and
20 Allen, Larry and I and Deb, I guess there on we're clear that
21 we're recommending that this brokerage function be set up in
22 the private sector. And then there was some discussion, well,
23 does that mean that there should be some state government seed
24 money to get it started? Or the other side of the argument
25 was, hey, if this of value and somebody, like ASTHMA, for

1 example, starts it up -- if it's of value, it should pay for
2 itself, really virtually, from the get go, and you shouldn't
3 look -- have it be something that government has to put money
4 in to get started, and I don't think we came to a resolution,
5 but there was that discussion. I think it relates to what you
6 say there. I don't disagree with Val's concern, but -- or it
7 is too much micro-management or attempted micro-management of
8 the Commissioner to say he shouldn't do it? I absolutely
9 don't disagree with what you're saying or what Val's saying,
10 that there can be a propensity to go out and get lots of
11 consultants, whether it's the U.S. government or the State of
12 Alaska government.

13 COMMISSIONER HARRELL: So I mean, that's all I'm looking
14 for is your north-south or east-west on that propensity. You
15 know, coming from a military perspective, as Commander, I want
16 my boss to say to me, Harrell, go do that. I don't want them
17 to tell me how to do it, just go do that. And then I'll go
18 execute because he trusts me to do the right thing, which is
19 really what Jeff's comment is. Hey, let's just leave it
20 departmental and expect everybody to go. However, an inherent
21 distrust of human behavior is reasonable. That's all I'm
22 asking.

23 CHAIR HURLBURT: Put in the amendment "a healthy
24 distrust?"

25 COMMISSIONER ERICKSON: I don't want to interrupt the

1 conversations, so continue the conversation, but I just want
2 to show you what I've done on the screen. The first number
3 two is the original wording of the recommendation. The second
4 number two is the new proposed wording with all of the
5 strikethroughs and underlines taken out, so you can read how
6 it would actually be worded, if we vote on this effort. Dave?

7 COMMISSIONER MORGAN: As I remember -- and if I've got it
8 incorrect, please update me -- the whole premise around this
9 is I know that there -- the Exchange, the Information Exchange
10 is mandated. You've got to have one, one way or another. If
11 you hit the ground with a stick and it just comes out of the
12 ground, there has got to be one is the way I understand it. I
13 know that there was an infusion of capital money right around
14 \$3.5 million in the last budget, and we have a legislator here
15 that will probably get us down to the penny.

16 I think the overall concern is -- and I think you're
17 going to -- we're running up against this -- this is my view,
18 no one else's -- especially in large small-population states,
19 the number of people you've got to make some of these run
20 makes the fixed costs incredibly high per unit. And I think
21 that's what's -- everybody that does a balance sheet or does
22 any of those ROIs to justify going to the bank and getting
23 some money -- I think the overall consensus in the room of
24 most of us was, hopefully, there is some way to monitor this
25 so it doesn't rely on state money, but that's -- as pointed

1 out by our colleague from the Chamber of Commerce, how many
2 times have we heard that? How many times, again, do we have
3 silos that kids are bouncing basketballs off the sides of
4 them? You know, how much of that can you do? And sometimes,
5 we need to look at, like you said, how we do this and who does
6 it.

7 And I'm in a quandary, too. We're sort of -- we've got
8 to do it. We've got one information -- we've got an
9 information group sponsored under government to sort of do
10 some of this already and has been doing some of it. So I
11 think our natural inclination was to kind of migrate to that
12 group because, at least, they're doing some statewide stuff
13 with telemedicine and actually doing some stuff.

14 So the question was, you know, I'm kind of -- I'm like a
15 feather in the wind. There for a while, I was thinking about
16 restricting some of the language, but maybe the 50,000-foot
17 level -- and hope that the Department can make this in a
18 context of, hey guys, go do it, but let's see if we can do it
19 in a way where they're not going to the Finance Committee and
20 getting millions of dollars to do it. And I don't know if
21 that's possible. It could be that we're so small, population-
22 wise.

23 I think the one thing that might get it there is
24 piggybacking it on our current systems that are operating that
25 are doing telehealth, like AFCAN, like what the tribes are

1 doing and some others, Providence and that, but now I'm
2 getting down in the weeds, which is where we don't want to go.

3 So I think general language, and I mean, we're not going
4 out of business. We'll still be around. And we're just going
5 to have to do a leap of faith here, I think, that they won't
6 go to a consultant, but if they do, I think we'll talk to them
7 about it.

8 COMMISSIONER ERICKSON: Pat?

9 COMMISSIONER BRANCO: Remember our earlier caution. We
10 have no authority. This is simply a recommendation. What
11 language we put in here is simply a recommendation, and it
12 will or will not be followed. So I think we get the best
13 general intent. And my eyes glazed over through the middle
14 part, but I'm back and ready to vote.

15 COMMISSIONER ERICKSON: Wes?

16 COMMISSIONER KELLER: Let the record reflect that I was
17 able to keep my mouth shut when you asked if there was a
18 propensity to spend money.

19 COMMISSIONER HARRELL: Although your head did move.

20 COMMISSIONER ERICKSON: So Val, just to make sure, you
21 had accepted the second change as a friendly amendment?

22 CHAIR HURLBURT: Tom?

23 COMMISSIONER HARRELL: Sir, I'm good. I posed that,
24 simply again, as someone who has come into the state, but I am
25 perfectly comfortable with the department level language on

1 there, by virtue of that's the way I practice.

2 CHAIR HURLBURT: Val?

3 COMMISSIONER DAVIDSON: (Indiscernible - away from mic)

4 CHAIR HURLBURT: All in favor of the wording, the second
5 wording there, aye.

6 COMMISSIONERS IN UNISON: Aye.

7 CHAIR HURLBURT: Opposed, no. Carries. Thank you very
8 much.

9 COMMISSIONER ERICKSON: Thank you. Moving on to End-of-
10 Life Care, we are -- now I've messed up my slide numbers by
11 adding that slide. So we are on slide 30. Thank you. And so
12 comments we received related to the End-of-Life Care section,
13 a number of comments from folks who were supportive, in
14 general, of the section, and more specifically, supportive of
15 the recommendation that the State evolve from Comfort 1 to a
16 POLST program, and one particular suggestion that, if this new
17 program gets created, that it not be called POLST.

18 The reason I had included reference to both POLST and
19 MOST is to the extent that a form has been developed and is
20 being used, at least, in one hospital here; they call it
21 Medical Orders. A concern was that it refers to physicians,
22 and we have other clinicians who have the ability to prescribe
23 treatment. So where it has been used in the state, it's MOST.
24 I've wanted to make sure that we were referencing POLST
25 because that's a national program. If anybody wanted to learn

1 more about it and Google it, they would find a lot more by
2 going to POLST.

3 A comment, again more specifically, supportive of the
4 recommendation related to more public education on the topic.
5 A couple of responses from leaders at the University of Alaska
6 specifically supportive of the recommendation, essentially, to
7 them that healthcare provider education curriculum do a better
8 job of addressing training for End-of-Life Care, education
9 around End-of-Life Care for clinicians in the educational
10 phase.

11 There were some clarifying edits -- I took them as
12 clarifying edits -- and real specific changes that were being
13 made and so I have incorporated those clarifying edits. They
14 came from a couple of different places, and you would find
15 those on pages 20 and 21 of the public comment packet and also
16 page 37 of that packet from the Nurses Association and from
17 the Director of the Hospice of Anchorage. So we'll look at
18 those in a minute.

19 And then a number of comments that were supportive of the
20 recommendation related to the registry as well, and more
21 specifically, a suggestion that that registry also include
22 advanced psychiatric directives.

23 So those were the comments that we received, a brief
24 summary of the comments. Anybody have any questions about the
25 summary of the comments that we received before we move on to

1 look at -- or the comments in general before we move on to
2 look at the suggested rewording? I'm hearing none and seeing
3 no questioning looks.

4 We are on slide 33, which is where the majority of the
5 changes are. I was just looking ahead. We do have a couple
6 of changes on slide 34 and also on slide 35, but then that's
7 it. And all of these suggested edits are to Finding
8 Statements. We didn't have any suggested changes to the
9 Recommendation Statements.

10 COMMISSIONER URATA: Motion to approve.

11 COMMISSIONER BRANCO: Second.

12 COMMISSIONER ERICKSON: So Dr. Urata moved to approve the
13 proposed changes. And just to clarify, Dr. Urata, are you
14 moving all of the changes on all three slides?

15 COMMISSIONER URATA: That is correct.

16 COMMISSIONER ERICKSON: And Pat seconded.

17 CHAIR HURLBURT: Any discussion? All those in favor,
18 aye.

19 COMMISSIONERS IN UNISON: Aye.

20 CHAIR HURLBURT: Opposed, no. It carries. Thank you.

21 COMMISSIONER URATA: See, Val. That's how it's done.
22 I'm just kidding. I'm just teasing you. I'm just teasing
23 you.

24 COMMISSIONER DAVIDSON: I love it. You, too, Allen.

25 COMMISSIONER ERICKSON: Any other questions or discussion

1 on End-of-Life Care before we move on to our next section?

2 COMMISSIONER BRANCO: So I've just got to say that's the
3 gamesmanship strategy, follow immediately with a lot of
4 changes, after you've had a tenuous discussion on simple ones.

5 COMMISSIONER ERICKSON: Yes, Allen?

6 COMMISSIONER HIPPLER: This is a comment, not a motion.
7 I won't waste time because we've already beaten this to death,
8 but there is a segment of our population that does not believe
9 that it is the responsibility of the Governor or Legislature
10 to educate people regarding end-of-life planning.

11 COMMISSIONER ERICKSON: Moving on then to the final
12 section of our recommendation portion of the report regarding
13 the employer's role, and again, just to summarize very briefly
14 the comments that we received, you can see that the page
15 numbers to reference the exact comment. A comment that was
16 supportive in general. A couple of comments regarding an All-
17 Payer Claims Database, which really isn't part of our
18 recommendation, really just meant to note for the Governor and
19 the Legislature the continuing work that the Commission will
20 do in the next year. A comment that was supportive of the
21 idea of a database to support public transparency. And a
22 suggestion that a stakeholder group be formed to plan next
23 steps related to an All-Payer Claims Database. A suggestion
24 that the State provide nurses and (indiscernible - voice
25 lowered) for public employees. A note that the healthcare

1 industry is also an employer and that the State be mindful of
2 the complexity and fragility of the healthcare system,
3 especially in rural areas, moving forward with strategies that
4 we've heard about from Commissioner Hultberg and also being
5 mindful of unintended consequences. A concern raised
6 regarding the consumer-directed health plans and coinsurance
7 and how that might or can discourage necessary care and also a
8 suggestion that the State should counsel their own employees
9 regarding Medicare enrollment and retirement. So that is just
10 a summary of the comments related to this section that we
11 received.

12 I had no clarifying suggestions for this section, based
13 on those comments, so if anybody wants to raise anything more
14 substantive or has questions?

15 CHAIR HURLBURT: Should we move on?

16 COMMISSIONER ERICKSON: Are you all prepared to move on?
17 There were quite a few comments related to workforce, and
18 again, we just, in the interest of providing context and
19 making sure folks were reviewing the draft, understood that we
20 had looked at workforce issues in the past, had summarized it
21 very briefly in the report, but we did receive a number of
22 comments, related to that, supportive of the loan repayment
23 program that was just instituted, appreciation of the emphasis
24 on growing our own in terms of workforce, somebody citing
25 particular frustration with state CNA regulations and the

1 federal law related to that or regulations being interpreted
2 by the State, a suggestion that we have a standing
3 recommendation supportive of developing family medicine, not
4 primary care residencies, including internists and
5 psychiatrists, and there was a suggestion that more family
6 medicine residencies are a good idea, but we don't necessarily
7 need internists and that more incentives are needed for family
8 medicine resident graduates to live and practice in rural
9 Alaska, some questions about the Health Workforce Coalition, a
10 suggestion that medical school should be fully subsidized by
11 the government, that strategies to increase primary care
12 physicians should include nurse practitioners, and some
13 information about the osteopathic medical school. And that's
14 it. We should continue these efforts.

15 So those were comments related to workforce. Does
16 anybody have any questions or want to discuss any of those
17 healthcare workforce development comments that we received?

18 Hearing none, we also received a comment related to the
19 health information infrastructure similar to the one about
20 telemedicine that, as the use of electronic health records
21 increases, problems need to be monitored and providers need to
22 be properly trained.

23 A comment suggested that support for the work on
24 evidence-based medicine -- also a concern related to that,
25 that there be some caution regarding over-application of

1 evidence-based medicine to uncommon conditions where research
2 might be limited.

3 A suggestion that we continue to emphasize strategies to
4 implement patient-centered medical homes, and a suggestion
5 that the State track primary care access for Medicare
6 beneficiaries.

7 Any questions or comments or suggestions related to
8 those? And I broke those out from "Other" because those were
9 areas where the Commission had previously studied and
10 developed recommendations.

11 So I lumped everything else that didn't fit somehow into
12 the Commission strategies or current or prior work into this
13 "Other" category. And so there were a couple of comments
14 related to the Insurance Exchange, to oral health, the
15 availability of tools that support medical consumerism.

16 There were a number of issues related to certain special
17 populations that were raised. We had a number of comments
18 from folks involved with the Traumatic Brain Injury Network
19 about that problem in the state and lack of services for folks
20 suffering from that condition, for persons with disabilities,
21 with Multiple Sclerosis, and older Alaskans. So those were
22 special populations that were addressed in those comments.

23 Suggestions related to tobacco and obesity control and
24 specific suggestions for state regulation regarding those.
25 The need for increased home health care services was noted.

1 There were a couple of recommendations related to Medicaid
2 expansion under the Affordable Care Act. A concern noted
3 about challenges that adolescents face as they age out of the
4 pediatric system and also out of Medicaid, for kids who are
5 covered by Medicaid. Support for prevention and population
6 health in general. A suggestion that the Commission
7 specifically develop a score card for the State's healthcare
8 system with indicators and trends. A suggestion that, in
9 addition to considering the consumer's role, we also consider
10 the community's role in health and healthcare and that we also
11 study not just evidence-based medicine, but evidence-based
12 practices to engage Alaskans in healthy lifestyles, that we
13 consider establishing a Permanent Fund for health and
14 wellness. Comments related to the problem of Alzheimer's
15 disease and related dementia, and a suggestion that we
16 increase our focus on wellness, holistic health and self-care,
17 and also that we consider the Integrative Medical Model.

18 So that was a long list, but of all of the other topics
19 that were raised. Does anybody have questions or want to
20 raise discussion on any of those points? Keith?

21 COMMISSIONER CAMPBELL: Well, I've read all of the
22 comments about the traumatic brain injury, and I'm trying to
23 go back, at least in our community, and see what.....

24 COMMISSIONER ERICKSON: Keith, can you put your mouth a
25 little bit closer to the mic?

1 COMMISSIONER CAMPBELL: Certainly can. I'm just trying
2 to think about the numbers in our community of these people,
3 and I think it's probably way less than on one hand, as I -- I
4 know the community.....

5 COMMISSIONER ERICKSON: In your community specific.....

6 COMMISSIONER CAMPBELL: Yeah. So I'm just wondering how
7 large -- I mean, it's a terrifying thing for people that can't
8 -- and families to have to deal with, but I just wonder how a
9 treatment facility or things would work on a statewide basis.
10 There are a lot of people here that have got more information
11 than I do, but I just -- I feel for these people, and I feel
12 for the families, but I just don't know how you address
13 something in such remote and diverse areas that these people
14 do reside in.

15 CHAIR HURLBURT: Let me share some perspective on that.
16 Larry and I talked earlier, as I mentioned. There is a
17 constituency because this can be such a devastating thing, but
18 there are significant numbers of Alaskans, not big numbers.
19 And as I was mentioning earlier, Larry was telling me he had
20 visited their center at the Mayo Clinic there. A large staff.
21 Great capability there. But they require ten to 15 new
22 patients a week to keep that center going there, as a real
23 resource. It's not the only national resource for that, but
24 one of the few limited ones. And so I think, maybe consistent
25 with the intent of what you're saying there, it's like, if you

1 have a 60% burn, you should not be cared for in Alaska. You
2 need to go to Harborview. You need to have a regional center
3 for certain kinds of things to do that. I believe that it
4 makes sense for us to look at that kind of a referral ability.
5 Anything else?

6 COMMISSIONER PUCKETT: So would it be accurate to say
7 that traumatic brain injury could be one of those things that,
8 due to Alaska's small population, we probably are just going
9 to have send those people out to a regional center, like a
10 burn?

11 CHAIR HURLBURT: It would depend on the severity because
12 there is a wide spectrum, and there may be some people that
13 would have that kind of a diagnosis who could well be cared
14 for here; wouldn't you agree, Larry?

15 COMMISSIONER STINSON: Yeah.

16 CHAIR HURLBURT: But for those where it's really severe,
17 they're going to be best served by getting into a place where
18 you can have the intensity of service, like the Mayo Clinic.
19 Larry?

20 COMMISSIONER STINSON: We've seen some of the traumatic
21 brain injuries from the Wounded Warriors program, and they've
22 got, actually, a fairly decent system on Base for that.
23 That's actually the best capability that I know of in the
24 state because, between speech pathology, neuropsychology,
25 different rehab doctors, occupational therapy, physical

1 therapy, you're talking about a very specialized group that
2 can't be sitting around all the time waiting for the next
3 patient to come in.

4 So on one hand, I'm very sympathetic because these are
5 devastating injuries. On the other hand, to get a group, like
6 that, together and to keep them together, there has got to be
7 the numbers, just like you said, like the burn unit. You
8 don't want to be the one person treated for a 60% burn in the
9 state of Alaska and say let's try this. That won't fly.

10 CHAIR HURLBURT: Yes, Tom?

11 COMMISSIONER HARRELL: Just to echo Larry's comments,
12 it's true. Our staff is in excess of 20 individuals and
13 that's in direct support of the 425 and the 125, and it is a
14 very manpower-intensive, costly project. We do it, of course,
15 in support of the war fighter, but both of your comments are
16 spot on.

17 CHAIR HURLBURT: Thank you. Any other comments? Bob?

18 COMMISSIONER URATA: In Juneau, we have a speech
19 therapist who works with these folks for cognitive problems,
20 and of course, physical therapy and occupational therapy, but
21 for, you know, physician care and follow-up, we end up sending
22 them to Seattle to Harborview.

23 CHAIR HURLBURT: Thank you. Anything else? Deb?

24 COMMISSIONER ERICKSON: Any final questions or discussion
25 on the other topics raised in the public comments before we

1 move on to plans for studying strategies for next year?

2 So now I am on slide 43, I believe. Yep. And there are
3 no suggested changes to this list, at this point. And our
4 plan is to continue exploring the employer's role with the
5 business community; price and quality transparency, so
6 receiving the final report from the All-Payer Claims Database
7 consultants; delving a little bit deeper into evidence-based
8 medicine; then continuing to track all of our prior year
9 recommendations. Any questions or discussion? Yes, Val?

10 COMMISSIONER DAVIDSON: I just had a question. I think
11 we talked a little bit about some of the ideas for 2013. So
12 at this beginning slide, Deb, are those going to be added here
13 then as well or is this a different.....

14 COMMISSIONER ERICKSON: Well, it's different. What we
15 addressed at the beginning of the slide deck were -- I mean,
16 they're all things that we'll study during 2013, but the set
17 of things that we identified at the beginning of the meeting
18 were issues related to understanding better the current system
19 and how the current system works, where we're not going to
20 develop recommendations specific to those, to that learning
21 that we'll do, but it's just to help inform us better, and we
22 might have some findings related to them. These are specific
23 strategies for then moving towards the vision and away from
24 baseline current conditions to improving cost, quality, and
25 access in the system and health overall. Yes?

1 COMMISSIONER DAVIDSON: So just to clarify, but if in the
2 course of our study where we're learning about those other
3 things -- I'm thinking of oral healthcare, for example. If,
4 during the course of that, we realize that there are some
5 things that we want to be included, then we're not precluded
6 from doing that?

7 COMMISSIONER ERICKSON: Yeah, and we, I think, set a
8 precedent, at least, with the one area I can remember is
9 trauma system, where we were just studying the trauma system
10 to understand better the current condition, but then developed
11 recommendations related to that, too.

12 COMMISSIONER DAVIDSON: Thanks.

13 COMMISSIONER ERICKSON: Other questions/discussion? Yes,
14 Emily?

15 COMMISSIONER ENNIS: I want to make sure that we have a
16 focus, once again, on behavioral health, and I know there were
17 a number of comments that perhaps we had not spent enough
18 time, once again, on behavioral health. So could you help me
19 determine, in fact, as we look forward to 2013, where we are
20 going to look at that, if at all?

21 COMMISSIONER ERICKSON: Right now, we wouldn't. The way
22 we're addressing the concern was that we will include a write
23 up in the 2012 report of what we learned at that March meeting
24 from the presentation. Yes? Question?

25

1 (Pause - background discussion)

2 COMMISSIONER ERICKSON: Well, the list related to
3 behavioral health -- let's see. This was -- these were the
4 recommendations that we have. So this is the section of our -
5 - this is how I've grouped them, again going to back the
6 pyramid designed for our strategy. I've broken up and
7 categorized our recommendations for transformation strategies
8 around making healthcare delivery more -- coming up with
9 strategies for innovations in healthcare delivery to make it
10 more patient-centered and to focus on improvements in
11 healthcare delivery and then the second category being what we
12 could recommend to enhance the consumer's role in health --
13 supporting healthy lifestyles.

14 And so this bullet regarding behavioral health is
15 specific to the recommendations that you guys came up with
16 last year that were related to how -- it wasn't about -- well,
17 it did address behavioral health services.

18 So it's our standing recommendations, which are related
19 to screening for behavioral health conditions. We have three
20 bulleted -- a list of bullets of three different conditions
21 related to behavioral health that we had recommended that all
22 healthcare providers screen their patients for those
23 conditions, substance abuse, depression, and adverse childhood
24 events, and another recommendation regarding the need to
25 integrate behavioral health and primary care services. So

1 those are the specific recommendations that we're continue
2 tracking. Yes?

3 COMMISSIONER ENNIS: Thank you. I just -- I know it will
4 weave itself throughout a lot of our discussion, but we have,
5 from year one, talked about the fact that issues related to
6 behavioral health impact greatly our primary care system.
7 They affect our elderly significantly, in many ways that we,
8 often, are not able to address. Then you know, the cost
9 that's involved in disruptions to society are all issues that
10 occur all around us. So again, I just want to make sure we
11 don't lose that as we go into the New Year.

12 Again, I'm sure that the various specific issues will
13 arise during our discussion, but again, as a representative of
14 the Alaska Mental Health Trust, it is one of our most primary
15 concerns. Our availability of services, whether we begin at
16 the psychiatric level or even go down to the more direct
17 (indiscernible - voice lowered), are inadequate, particularly
18 for specific populations. It's a great need in Alaska, and I
19 just want to make sure I continue to remind all of us of that.
20 Thank you.

21 COMMISSIONER ERICKSON: And one other -- Pat has a
22 comment, too, but one of the other things that I wanted to
23 point out is the bullet under that, that we'll continue to
24 track development of Healthy Alaskans 2020, and I know -- I'm
25 participating on the Advisory Team for that group and know

1 that they have identified a number of issues related to
2 behavioral health, and I'm sure it will come through in that
3 evolving work. Yeah, Pat?

4 COMMISSIONER BRANCO: Very quickly, I want to add
5 emphasis to Emily's position there. It has so many impacts on
6 our provision of healthcare. You referenced the impact on
7 primary care physicians becoming de facto psychiatrists in our
8 community, taking calls, and dealing with the mentally ill and
9 other behavioral health issues. There are also areas that we
10 may need to focus on over time. We have disparate treatment
11 in our court system. Our rules and regulations don't always
12 advocate for patient protection versus individual protection,
13 and treatment is not always synonymous with confinement. And
14 so we run into a lot of challenges that are very difficult for
15 small communities, large communities to deal with individuals
16 who are deeply affected by the policies in place, and we get
17 people caught in the middle. And I think this is an area that
18 we could focus on, again, for access and availability for
19 care, with a focus on these individuals.

20 COMMISSIONER ERICKSON: Other discussion or questions?
21 That actually wraps up the review of the public comments and
22 changes related to those. So thank you very much. Does
23 anybody have any final comments before we move off of that
24 part of the agenda and move on to Affordable Care Act update?
25 Yes, Pat?

1 COMMISSIONER BRANCO: I think the pre-work that you did -
2 - the tons of work that you did to make this a simpler process
3 for us -- I remind people of the summary document -- that was
4 so helpful in weeding through the really profoundly good
5 comments made by the public who have weighed in, in such
6 surprising detail and with genuine passion, but your work to
7 summarize and aggregate and then put it in a logical format
8 and those places where there are places recommended, you're
9 really to be commended. This is exceptional work.

10 COMMISSIONER ERICKSON: Yes, Val?

11 COMMISSIONER DAVIDSON: And just special appreciation. I
12 thought you were really, really true to the intent of people's
13 comments and that is not an easy thing to do, and you did also
14 with brevity, which is nothing short of miraculous. So thank
15 you.

16 COMMISSIONER ERICKSON: Thank you. And truly, I hope
17 you'll call me if I ever -- if you think I'm mischaracterizing
18 something. Call me on it. Should we move on to the
19 Affordable Care Act update?

20 So on -- it must be slide 46. So I just put together a
21 list of bullets of the things I've been tracking. As I
22 mentioned, Commissioner Streur is traveling today and so
23 wasn't available to come brief you himself. I wanted to note
24 -- well, of course -- and these are just significant
25 developments since we had our last update at the October

1 meeting. So of course, most significant is the outcome of the
2 presidential election.

3 The Department of Health & Social Services -- this is
4 something we haven't talked about in detail and maybe in a
5 real early presentation a couple, three years ago, but the
6 Affordable Care Act includes some pretty significant changes
7 related to protecting the vulnerable older Americans. It
8 significantly increases the role of the federal government in
9 addressing and financing concerns in that area. And so if
10 you're interested in learning more at some point, we can pull
11 that up, but I wanted to note that our Department received a
12 \$1.0 million grant from one of the programs established under
13 that section for elder abuse prevention. And so that program
14 will be starting shortly, and if you have questions about it,
15 I could provide more information for you about that new
16 program.

17 It's, essentially, going to be testing some new case
18 management models to see how to help elders avoid fraud and
19 other things that they might be more susceptible to, problems
20 that they might be susceptible to and that's what these -- why
21 there is such a small number. It's not to start a new program
22 in other states. It's to test new models and new
23 interventions to see what's the most effective. So that's why
24 it's a real small number of states that receive these.

25 As far as the Insurance Exchange, we had heard from the

1 Commissioner that there was an anticipation of some of the
2 deadlines being moved back and that happened a little bit. So
3 states that are going to be establishing a state-based
4 exchange had the deadline pushed back to this month for filing
5 their Letters of Intent. And then for those states that are
6 going to establish their own exchange under the federal rules
7 or will partner, in some way, have to submit what's called a
8 blueprint to provide some more detailed plans of what their
9 intentions are, beyond a Letter of Intent, and that deadline
10 was pushed back as well. All of the blueprints were due on
11 November 16th and now they are pushed back to February 15th.

12 I've just been including, in each of our updates, the
13 number of folks enrolled in the high risk pool plan created
14 under the Affordable Care Act and that really hasn't varied.
15 The number hasn't varied. I know we heard a story, at one
16 point, about folks kind of going on and off that plan, but I
17 think it's been around between 43 and 47 every month we've
18 looked at it.

19 And then a whole series of new federal regulations came
20 out, some proposed. I think one of these is a final set. And
21 again, it was something that we were hearing from Commissioner
22 Streur and Josh, some of their frustration with all of the
23 planning that needs to happen and decisions that need to be
24 made and waiting for the details of what the federal
25 government will require.

1 So one, I went ahead and noted it. I probably didn't
2 need to because it's not relevant to Alaska. Alaska is one of
3 just, I think, no more than four states. It might even be
4 two.

5 One of the provisions in the Affordable Care Act requires
6 that Medicaid payments for primary care physicians,
7 specifically, be increased to the Medicare level, and in our
8 state, we're one of the few states where Medicaid payments for
9 primary care are actually higher than Medicare, but in most
10 states, it's actually lower. And that regulation was
11 released.

12 The proposed regs for the exclusion that will take effect
13 in 2014 excluding -- the prohibition for insurance companies
14 to not exclude folks with pre-existing conditions anymore for
15 adults. That took effect for kids when the law was
16 implemented and now it will for adults in 2014. Those
17 regulations came out.

18 Regulations that, essentially, add a series of consumer
19 protections related to employment-based wellness programs was
20 released this past month.

21 And regulations and also a CMS Guidance Letter related to
22 Essential Health Benefits, the policies and standards for
23 coverage in private insurance plans and then the direction
24 from the Director of CMS related to Medicaid, Essential Health
25 Benefits in Medicaid came out this past month.

1 And then finally, just a week or two ago, proposed
2 regulations regarding how the federal Office of Personnel
3 Management is to implement multi-state health plans in every
4 state. The Affordable Care Act included a requirement that
5 the federal Office of Personnel Management contract for every
6 state to have, I believe, if I'm remembering correctly, at
7 least, two multi-state health plans and that they were
8 supposed to establish those under contract. So that came out
9 just a couple weeks ago.

10 Does anybody have any questions that I might not be able
11 to answer off the top of my head here, but could track down
12 information for you on related to the Affordable Care Act?

13 COMMISSIONER MORGAN: Well, this is not a question, but
14 Friday, the Internal Revenue Service -- I've got it in my hand
15 -- put out the minimum value of an employee-sponsored health
16 plan, assessing their rules on what will do. It's Notice
17 2012-31. There are some -- it relates back to what the
18 Commissioner has been saying from the Exchange and other
19 areas. They're sort of jumping into these things and then
20 you're getting regs. And this position of the IRS of
21 defining, you know, where the 60% of costs and how to define
22 it, will probably have some pretty significant hits or make
23 issues, especially developing AV calculators and MV
24 calculators and minimum values of plans to meet the
25 qualifications to be in a plan, stuff like that.

1 COMMISSIONER ERICKSON: I don't want it.

2 COMMISSIONER MORGAN: Okay. So only people that don't
3 have a life, like me, read this kind of stuff, so.....

4 COMMISSIONER ERICKSON: Any other questions about the
5 status of the Affordable Care Act? Yes, Val?

6 COMMISSIONER DAVIDSON: Not a question, but a comment. I
7 really appreciate the update. It's really helpful.

8 COMMISSIONER DAVIS: Again, not a question, just a
9 comment. That's a lot of stuff, you know, and everyone --
10 people in the business have been waiting for this to come out,
11 and likely, it raises more questions than it answers, but just
12 to the complexity of it, our team is going to spend an entire
13 day next week just trying to understand, at least, the surface
14 level of what all that means, the implications for customers
15 and for the business, et cetera. It's really complicated
16 stuff, so thank you for the summary.

17 COMMISSIONER ERICKSON: Well, we are going to end extra
18 early today, and we do have lunch coming in. So we'll just
19 invite folks up off the street, if nobody wants to stay and
20 eat it, but I'm not ending yet. But I am prepared to move on
21 to kind of wrap-up and next steps, if all of the rest of you
22 are. Do you want to take a long break and wait for lunch?
23 Okay.

24 And just to wrap up, I guess one of the things I would
25 note -- I've gotten in the habit of holding off on scheduling

1 too far in advance our meetings because then we run into
2 problems with folks' calendars. So I'm trying to find the
3 right balance, and I know, especially for our private practice
4 physicians here, that it makes it especially hard for them to
5 not have meetings scheduled well in advance and especially
6 hard when we change them.

7 COMMISSIONER STINSON: My office has already requested
8 all dates for next year.

9 COMMISSIONER ERICKSON: Yeah. So I don't know if it's
10 better to go ahead and schedule all the meetings a year in
11 advance?

12 COMMISSIONER STINSON: Yes.

13 COMMISSIONER ERICKSON: Yeah. I'm hearing lots of --
14 seeing lots of heads nod. So what we'll do -- and I
15 apologize. I didn't introduce Barb. I was just going to
16 refer to Barb. I need to introduce you to our new
17 Administrative Assistant. Barb Hendrix started just a couple
18 weeks ago or so or a month ago and has just been fantastic.
19 So I really am excited to have her onboard, and as you get
20 some logistical communications, especially for travelers,
21 you'll work more closely with her. But you might hear from
22 Barb periodically and now you can put her name with a face.

23 So what we'll do is we'll send out a scheduling poll,
24 like we normally do, and see if we can identify some potential
25 dates in each of these months. It might vary by a month or so

1 -- and the suggestions, and we'll try to get those scheduled
2 in the next month or so. Yes, Bob?

3 COMMISSIONER URATA: Will there be anything in February
4 because I'm making a February schedule now for our clinic?

5 COMMISSIONER ERICKSON: No. One other thing that we will
6 be doing in 2013 -- so I just wanted to note this, that we're
7 all keeping this in mind as we go through into our next year,
8 is that the Commission -- the legislation that established us
9 set a sunset date for June 30th, 2014. So one of my hopes is,
10 in addition to all of the other work that we're going to do,
11 that we've identified that we're going to do during 2013, that
12 we pull forward and try to put together in a comprehensive
13 package, so folks don't have to go back and reference prior
14 year reports, all of our current standing recommendations.

15 And I did give you all a document, at our last meeting,
16 that pulled together into a single document just all of our
17 recommendations, but I think we should spend a little time in
18 the next month, without getting too deep into process,
19 spending too much time with process, but pulling that together
20 so it is a little more understandable.

21 And I'm going to just pass this one document out, just to
22 give you a sense of one of the things that we might do. We
23 don't need to comment on this right now, but this is a two-
24 page summary that attempts to organize, in a different way,
25 and pull together all of our recommendations so far. And

1 where this format came from is a new approach the Department
2 of Health & Social Services has revisited over the past
3 several months, their leadership team, identifying and
4 clarifying their mission and measures, and they've updated all
5 of their measures. And I don't think that any of that -- I'm
6 not sure if that's been released to the public yet. Ward, I
7 don't think it has been, but it will be. It will probably
8 come out either with the Governor's budget or in preliminary
9 presentations that Commissioner Streur will be making to the
10 Legislature at the beginning of the legislative session. But
11 this has taken that same format, and I took a stab -- and
12 again, this is just very rough draft -- at identifying both
13 that general framework that's depicted in our pyramid and our
14 four goal areas and our approach and strategy into these four
15 different categories that are color-coded and identified a
16 priority statement related to each of those and then tried to
17 put -- take all of the things that we've made recommendations
18 around and drop them into where they seem to fit the best.

19 And I also thought it would be helpful if we think about,
20 for each of those areas we've developed recommendations, the
21 outcome that we're really striving to get. So again, this is
22 just a very rough draft and a suggestion that we'll look at
23 together, and I'll want a lot more direction from all of you
24 as we develop it. I thought, especially thinking about and
25 keying off a comment you made at one point, Allen, about

1 trying to make this stuff as simple and understandable and
2 readable for legislators as possible, and how do we boil it
3 down into a real simple package for a legislator to take and
4 look at and say whether they agree or not with a particular
5 priority or strategy or outcome and then they could delve
6 deeper in looking at more detailed information from the
7 Commission related to those. So that's more of an
8 informational piece to let you know, in terms of next steps,
9 what I think we should be doing in terms of process and
10 providing information on our recommendations next year.

11 With that, I guess we can see if there are any final
12 comments for the good of the group?

13 CHAIR HURLBURT: We're having a big flu year. If you
14 haven't had your flu vaccine, get it. It's H3N2, which is
15 early and tends to be more serious, but it's in this year's
16 vaccine. So if you -- if any of you or your family members
17 haven't received it, I would encourage you to do so. A lot of
18 Pertussis, whooping cough, more than ten times the expected
19 number, so again, encourage your families to do it. I'm
20 talking while you are gathering your thoughts, I guess.

21 One anecdote. There is what's called a Parran Report.
22 The first time the U.S. government really looked in a
23 systematic fashion at health in Alaska after the transfer of
24 sovereignty from Russia was done in 1954. Thomas Parran was
25 the Dean of School of Public Health, University of Pittsburgh.

1 It's over 300 pages. We've got it online. It's available for
2 any of you medical historians who want to read it. I read it
3 while I was on vacation, and one of the interesting things
4 that I picked up on is, in Ketchikan, in 1953 in a nine-month
5 period, there were 93 people with polio. And I don't know
6 what the population was then. Maybe 5,000 or so. And all,
7 except ten, were paralytic type polio, and the public health
8 nurses were busily giving the earlier polio vaccine, which was
9 a little more risky than what we have today. No comments
10 about parental hesitancy, but 93 cases of polio just in
11 Ketchikan in 1953. It's a fascinating report about medical
12 history in Alaska. Any.....

13 COMMISSIONER BRANCO: We're down to 88 now.

14 CHAIR HURLBURT: Any other comments about anything? Yes,
15 Keith?

16 COMMISSIONER CAMPBELL: Do we take a vote on the final
17 document?

18 COMMISSIONER ERICKSON: I skipped that part, since we had
19 voted on the individual findings and recommendations, but.....

20 COMMISSIONER CAMPBELL: I do agree.

21 COMMISSIONER ERICKSON:is that okay with everybody?
22 Would you like to vote on the final package? Okay.

23 COMMISSIONER MORGAN: I move we adjourn.

24 COMMISSIONER DAVIDSON: Second.

25 CHAIR HURLBURT: All in favor, aye.

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COMMISSIONERS IN UNISON: Aye.

CHAIR HURLBURT: Opposed, no. Thank you all very much.

COMMISSIONER ERICKSON: Thank you.

CHAIR HURLBURT: I hope you folks from Southeast can get
an earlier flight.

11:15:38

(Off record)

END OF PROCEEDINGS