ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

8:00:41

(On record)

CHAIR HURLBURT: We're right on time. I'd like to welcome everybody here. We have a busy, and I think, very interesting agenda for the next day-and-a-half. We'll start by having, first, all the Commissioners introduce themselves and then ask those in the room, here, to introduce yourselves –- and anybody and just mention if you're representing any organization. Then, I'll want to say a few words, and we'll get into the program here this morning.

So if we could -- I'm Ward Hurlburt. I'm the Chief Medical Officer of the Department of Health and Social Services. David, if you could introduce yourself, please?

COMMISSIONER MORGAN: Dave Morgan, representing community health centers, primary care.

COMMISSIONER STINSON: Larry Stinson, a physician representing providers.

COMMISSIONER KELLER: Rep. Wes Keller, State House.

COMMISSIONER HIPPLER: Allen Hippler, Chamber of Commerce.

COMMISSIONER CAMPBELL: Keith Campbell. I'm the Consumer Representative on the Commission.

COMMISSIONER DAVIDSON: Valerie Davidson, tribal health.

COMMISSIONER URATA: Bob Urata, primary care.

COMMISSIONER ENNIS: Emily Ennis. My mic is not coming on. I'm sorry. Emily Ennis, representing the Alaska Mental Health Trust.

COMMISSIONER PUCKETT: Jim Puckett, representing the Office of the Governor.

COMMISSIONER DAVIS: Jeff Davis, representing payers.

COMMISSIONER ERICKSON: Deb Erickson, Director of the Health Care Commission.

CHAIR HURLBURT: Thank you. If we could have, now, introduce the members of the audience, just go ahead just introduce yourself.

MR. RICHARDS: Bruce Richards, Central Peninsula Hospital.

MS. MONK: Good morning, Jeannie Monk, Alaska State Hospital and Nursing Home Association.

MR. ACARREGUI: Good morning, Michael Acarregui, Chief Medical Officer for Providence Alaska Region.

MR. BROWN: Fred Brown, Executive Director of the Health Care Cost Management Corporation of Alaska.

MR. HIRST: Mike Hirst. I'm the Director of Data Services at SouthCentral Foundation.

MS. STEPHENS: Donna Stephens, Executive Director at Hospice of Anchorage.

MR. MCCLUNG: Peter McClung, visiting from (indiscernible - away from mic) British Columbia.

CHAIR HURLBURT: And Peter gets the award for coming the longest distance for the meeting. Now he's been with us before, and (indiscernible - recording interference) is up here, but I mention it because, during the public comment period when Peter let us know he was coming, Peter is a Health Economist with the British Columbia Medical Association, and the (indiscernible - recording interference) on the All-Payer Claims Database type issues from the perspective of a different kind of healthcare system there in Canada. So welcome, Peter. Go ahead.

MS. BLAIR: Kate Blair from Pfizer Pharmaceuticals.

MS. GREEN: Linda Green, Freedman Healthcare.

MS. CULPEPPER: Delisa Culpepper, Alaska Mental Health Trust Authority.

MS. MARTIN: Monique Martin, the Alaska Native Tribal Health Consortium.

CHAIR HURLBURT: A few folks at the table that are supporting us and keeping us going, if you could introduce yourselves?

MR. WILLIAMS: Aaron Williams with IMIG Audio and Video.

MS. MORRISON: And I'm Sunny Morrison with Accu-Type.

MS. HENDRICKS (ph): I'm Barb Hendricks, Alaska Health Care Commission Assistant.

CHAIR HURLBURT: I'd like to welcome everybody here. There will be others coming in. I'd like to welcome all those

who are online. As always, we will have a public comment period today and that will be at 12:30 to 1:15. So both those of you who are online and those here in the room -- in the room, there is a sign-up place in the back of the room and the list there, and online, we will open it up for comments there later on.

Now, I'd like to talk -- before we get started with Commissioner Streur here, I'd like to just kind of set the stage a little bit for what we're doing, broadly speaking.

This is my fourth legislative session being in this job, as CMO in the Department, and I am impressed that, both those in the Senate and the House with whom we have talked, there is real engagement in and with issues related to healthcare and healthcare costs, both as an economic issue and as a challenge for Alaskans this year.

For those of you who have taken opportunity to watch some of the sessions, you've seen Commissioner Streur and Commissioner Hultberg's presentation. Lots of questions there -- Deb and I did as we talked about the Health Care Commission and our work here and that's been gratifying to me.

You've seen the email from Deb that the Legislative Audit function is beginning their function to look at the Health Care Commission and its work. We do sunset, under the law, next year, unless the Legislature and the Governor's Office extend us again. And so we have been working with them,

collaborating with them, trying to make that as good a process as possible, and Deb and I have both said, to them, that we will do all we can to help them, but since we report and send our recommendations to the Governor's Office and to the Legislature, it's from folks there that they really need to get the information. Is what we're doing of value? Is it helping? Is it making a difference? And if it's not, then it's a place to make a small savings in the state budget. But if it is, then, with the level of commitment that all the Commissioners have had consistently, we would certainly want to continue, but that's where the decision needs to be made.

We talk about healthcare quality. We talk about accessibility. We talk about costs. But this isn't just a discussion about healthcare. There were three items, just this week.

This is from the current issue of *Bloomberg Businessweek* magazine, and there is a graph in that, and this looks at government, federal government costs of what's happening with our national debt and so on. It goes from 2011 to 2051. I was kind of out of commission the last couple days, so I wasn't able to do this. But the bottom line shows other (indiscernible - voice lowered) programs, these black lines. There is discretionary spending, Social Security, all pretty level as a percent of GDP. The red line is healthcare costs, federal healthcare costs as a percent of GDP, and part of the

article was this is what's driving our federal deficit and national debt problem.

There was an item from the Federal Reserve yesterday that, with the release of their periodic *Beige Book*, it said, "Employers in several districts cited the unknown effects of the Affordable Care Act as reasons for planned layoffs and reluctance to hire more staff, said the March 6th Beige Book, which examined economic conditions across Federal Reserve districts." And then lastly -- and then this is an issue which -- and there have been very different opinions in our state, very different opinions among the members of the Commission, here, on the best thing to do, and this has to do with the expansion of Medicaid in Alaska, where Alaska was one of the states that has decided, at least for now, that it doesn't make sense. Governor Christie decided for New Jersey and said, we'd better get ours while everybody is getting theirs, and they decided on (indiscernible - background noise) that they would go ahead, and our Governor decided that, because of the financial implications and rationale, we wouldn't do that.

But this was a graph from Kaiser Family Foundation. Actually, it was published by Heritage Foundation, but this shows, for Alaska specifically, what the expenditures would be, and it shows the first three years a little bit below what we're currently spending for Medicaid, but their projection

from Kaiser Family Foundation, going up through 2022, was a difference of -- a cumulative difference of about $109 million more there.

So these are -- it's a controversial issue, I understand, but we are trying to deal with those issues so that our state could deal with all (indiscernible - background noise) most wisely in a way that does the most good for Alaskans, and I believe, in my contact with the legislators, I think that Representative Keller would echo it. They do appreciate the work that we're doing and the products that we have had there.

So without further comment, this morning, we have a session. We want to talk about breaking down silos, talk about the vision for the Department, which Commissioner Streur has been leading, has been sharing. He has worked not only to have those of us in the various divisions of the Department know each other, know our programs, work together, work symbiotically to try to achieve efficiencies and better results, but also reaching out agree other departments, and he has made me available to the Department of Administration to work with Jim and others there on a project that they have. So I'll turn it over to Commissioner Streur.

COMMISSIONER ERICKSON: Excuse me, Ward. Before we get started, I just want to check -- I think the person that we have on the line that we can hear who is not in lecture-mode, was Pat Bank. Pat, is that you on the phone? Pat, are you on

the phone? And Amy, are you on the phone?

MS. LISHKO: I am, Deb.

COMMISSIONER ERICKSON: I think -- I was just identifying the folks who are able to be outside of lecture-mode. We have a whole bunch of background noise coming in, and so if you could mute your phone, please? On your end, are you able to do that, Amy?

MS. LISHKO: Yes.

COMMISSIONER ERICKSON: Thank you very much.

MADAM COURT REPORTER: Yeah (affirmative). I think she was in her car is what it was.

COMMISSIONER STREUR: Good morning. Boy, it's nice to be back in Anchorage. Not that I don't like Representative Keller and the rest of the crew down there, but it's been an interesting year, to say the least, and you know, we're 52 days into it, I believe, and that means 38 days left -- but I'm not counting -- before, you know, this is all over.

There are a lot of things I want to talk about, but I want to give a quick overview of where HIE/HIT, Health Information Technological, Health Information Exchanges and all, is going. This is going to be a fast presentation, so we can get into a little discussion over things, but -- and then if Deb and Ward let me before they give me the hook, we can discuss what's happening down in Juneau from my perspective and then Representative Keller can say "what the Commissioner

really meant to say was," but let's move into that and into this presentation very quickly.

There is going to be a lot of history in here, too, and I wanted to bring it up because it's been, at least, a twinkle in my eye since I came to work for the Department and to begin to break down the silos not only in the Department, but in the state of Alaska with regards to technology. So anyway, here we go.

Health Enterprise Objectives. Optimize state and federal health programs, focusing on administrative efficiency and improving health outcomes. You know, I think that's still a vision in that I'm not seeing massive amounts of return on investment. We're spending massive amounts, but so far, the return on investment just is still, I think, a vision for us.

Leverage investment in Medicaid system for broader population. You know, before the fiscal cliff came along -- well, probably as the fiscal cliff was coming along, the Feds made a whole lot of money available to states to develop their technology regarding Medicaid, and what we've been able to do is leverage that 90% -- in some cases, 100% -- federal money with no match, leverage that for our other programs, such as expansion of our eligibility system for all programs. And so that is an objective. It's a continuing objective. I just hope the money holds out long enough for us to be able to realize the benefit of it because we're trying to spend, at

least, some of it as fast as we can and thanking the federal government for that.

Enable providers and other caregivers to become more efficient and effective at delivering care in Alaska's challenging geography. I'll talk about that later on, but we've made a considerable investment in this area.

Optimizing programs. Realign the focus of program administration toward controlling healthcare expenditures. You know, my philosophy is either loved or hated; I have to say that. A lot of folks think that "all he talks about is dollars," and others will tell you "he never talks about dollars." And so I try to talk a mental road on that, but we really need to look at controlling healthcare expenditures and that's not necessarily about less. It's about better. You all remember my mantra, and I promised I wouldn't say it again today. I won't say it again today, but you know, we do need to focus on the people and the specific needs.

Improving provider efficiency and effectiveness. I don't know what that looks like. It's a better use of technology, a better use of a physician and primary care and other providers' capabilities using it, as we can in improving -- excuse me -- population health outcomes. We've got to get better at what we do. We have to measure and show the effectiveness of that.

In order to do this, core functions, such as claim

processing, must work well. What does claim processing got [sic] to do with all this? Well, you know, basically, that's how we find out what it is we're doing to patients and with patients and for patients in our encounters, and (indiscernible - voice lowered) system is finally coming up. It's getting very close. We're in our third sprint, and we will be live by October 1. I told (indiscernible - voice lowered), I said, we will be live by October 1. Now that's your new mantra. And so they're working on it.

I'm not going to spend a lot of time on this, but the leveraging I've already talked about. There is a lot of federal money out there, and the Health Information Exchange, I remain cautiously optimistic it's going to work, and it's going to result in better care, but we have to make sure that the field is connected and willing to get along. And I say that because I think that is one of the big boulders in the middle of the road for us to realize this program, but we continue to work with everybody on that.

Greater Provider Effectiveness. I've talked about that, too, but you know, the right information to the right stakeholders at the right time. That's not my mantra, but it's close. It's got the same philosophy of it.

Automate previously manual processes. I can't believe how much re-work we do because of stuff that's not automated, not memorialized, not tracked, not computerized. It's tough.

Tie performance drivers and outcomes to administrative processes that providers must complete anyway, such as checking patient eligibility. I recently went through an experiment -- or not through an experiment -- an experience with one of our divisions where we required specific income information and found out that less than 30% of the folks that we had enrolled had that income information in the system, yet it was essential to the care process. We are fixing that, but it's those kinds of things and getting to -- everybody needs to be at the table. Everybody needs to have skin in the game, and there are no more free lunches. That's the best way I can put it. I'm hearing that loud and clear down in Juneau. It's that, you know, "Fix it, Streur. You're $2.6 billion of our budget." And when I look at the other departments, I think, holy smokes, we're a big part of the state economy, both in terms of outside revenue coming from the federal government and in terms of overall cost.

Drive all processes to real time. Man, it is so difficult to do that, and we're going to continue driving that direction.

The Roadmap. Implement the Enterprise. Establish program cost containment solutions. You know, cost management solutions fits a whole lot better with me and that is cost containment. Cost containment should be an outcome of cost management.

Integrate with the Alaska Health Information Exchange. Deploy clinical best practices through the Enterprise portal.

Here's -- this is the beginning of a set of historical slides. If it wasn't for Deb's rat-holing every single document that she's ever seen, I probably (indiscernible - background noise) document this by now, but she dug through her tomes and was able to come up with this long-ago slide. It was actually developed in November of 2007 -- I went back and found it myself -- and then added to over the years, but this is basically where we're going now with our healthcare Enterprise vision, to integrate everything and work from the basic MMIS functionality -- it's what we have now with EIFs and that -- toward realizing complete Alaska Medicaid Village, connecting everything and everybody that we do.

Public health, since I've got Ward sitting here. The number of systems, computer systems within public health that are just islands unto themselves just shocks me, and you know, the lack of connectivity that we have. We need to connect all this stuff. Dr. Stinson was talking to me this morning about some opportunities that we have, telemedicine, teletechnology. We've just touched the tip of what we can do with that, and we need to continue to develop it. If it weren't for ANTHC's leadership on this, we wouldn't be as far as we are, but we've still got a long, long, long way to go, but the capabilities are there. We need to pursue it. But you know, when Deb

pulled this slide up, I kind of smiled because I look at the visions now and I look at even the federal vision, and we were way too early on this one.

Once again, the Vision for Government Healthcare Programs. You have Value across the bottom, Program Impact going up the side, beginning with Transaction Processing. You know, there is a fair amount of impact, but -- a small amount of impact, but a fair amount of value from that because everybody gets paid and you're able to sustain provider systems and networks and that, but as you're going up, you see the Choice Counseling, the Health Information Technology, Analytics, and Care Management. And Care Management, I think you've heard me say it, but that, to me, is the key to us being able to do things, driving what we do back into primary care hands, controlling every connectivity between the three legs of the stool, the payer, the provider, and the patient, and making sure that all three are there and a part of it.

Updates. Electronic Health Record Incentive Program. I said I was going to talk about the leveraging of federal money. Well, $22 million -- nearly $23 million has been paid up. Nineteen hospitals, $12 million. Forty-one providers paid for Meaningful Use, $348,000; 341 providers paid for EHR adoption, $6.8 million. This is real money, and it's -- you know, I pray every night that, you know, let this work because it's a huge investment and getting -- but you know, I think

the big challenge that we have -- and we have a few physicians in the room -- is getting people to adopt it, getting people to use it, getting people to invest in it, getting people to say no, I'm not going to continue to dictate my notes. I'm going to enter it into the system, or if I want to continue to dictate my notes, have voice recognition so that it happens, because it works. I've seen it work, and the technology continues to improve on a daily basis for it. And you know, we continue to work the folks on that to benefit from (indiscernible - voice lowered), which is they're trying to recover $85 billion, you know, yet this fiscal year. I'm sure it's going to decline rapidly.

Health Information Exchange Update additional information. Over 4,000 users currently exchanging health information via Direct Secure Messaging. That has not been without its challenges, but it is improving. It improves everyday, the connectivity, the relationship with the vendor, as we begin to shake the bugs out.

We send way too much information via Direct Secure Messaging that doesn't need to go via Direct Secure Messaging, and I'm sure that we don't -- we also send information that should go via Direct Secure Messaging that we don't use it for.

State Lab Pilots are currently sending structured lab results via Direct Secure Messaging. Big rock, and we've

overcome it. We've passed over it. We've moved it out of the way. Take your pick. And it's fully functional and sending information.

State Health Information Technology Office received federal approval to move the HIE from Phase 1 to Phase 2. What does it mean? It provides information for query-based exchange to begin, basically, putting the rubber to the road on the exchange and really beginning to use it.

Fairbanks Provider Pilot. Electronic Health Record data download continued through 2012, and query-based exchange is scheduled to go live next month. So when I first saw this slide in January, you know, in the spring, then it became late spring, and now April, we're shooting for it. Hopefully, it's not April 1, but we will continue to move it forward.

A quick update on our two big projects that are underway. Medicaid Management Information System Replacement. We're in business process testing and making good progress. We've done -- what we're currently performing with the MMIS, Medicaid Management Information System, is a -- excuse me. I have some sprints, and these sprints where you're identifying specific challenges that you have with system operability, and you just go just a full effort to complete it with specific, identified objectives, steps along the way, and daily measurement. And we've done two sprints, and both of them have been 100% successful. And it's going back to what we did 20 years ago

when we implemented new MMIS systems, and they set it aside for, you know, different business processes, and things got bogged down, and things got siloed, and so they encountered great difficulty. And finally with this one, we identified about $32 million in penalties that we could access because of (indiscernible - voice lowered) with MMIS and that seemed to get their attention, since that was a $36 million contract. And so they decided to do this, and it's been working. It's been working very well. We're currently, as I said, in sprint three, and once sprint three is completed, the user acceptance testing will begin and that will continue throughout the summer and will go live in October. I say late summer. That won't be a true go-live. I think what we'll probably do is a couple of parallel tests with the existing system to make sure that we're paying everything correctly, as it should go.

Eligibility Information System. Last year, we had a unique opportunity come along, and the federal government offered us expanded 90% funding for EIS. It was not in our budget, but I got permission to go and work with our legislators to see if there was a willingness to make the commitment to upgrade this 28-year old system. And the legislators stepped forward, put up $8.4 million. I was able to leverage that against $62 million worth of federal money, and we're off and gone.

We had awarded the contract -- signed it last Thursday, a

week ago today, with Deloitte. Their NextGen system solution is a proven system. It's currently operating in 18 states. It's not vaporware. And the system will be implemented in two releases, Medicaid Eligibility Information -- or Eligibility Determination features will be operational by late this fall. I think that's pretty optimistic. You know, if we're ready by late this fall, I'm going to be very surprised. So shoot for winter.

And then the functionality to support the remainder of programs, such as temporary systems for needy families, those programs that are on the edge that you really can't say that it's related to Medicaid quite as clearly, heating assistance and some of those. That technology will be fully implemented by July of 2015.

Thank you. That's a quick overview. I want to say a couple things, if I could -- may I? -- about what's happening down in Juneau. It's not as chaotic as you may have heard. I would say that whether Representative Keller was here or not. It has been a very open process. I -- the -- I say "I." The budget for the Department has taken a $25 million hit at this point. There is no need for panic. We're only in the first sprint, you know, of the budget process. I continue to work with the legislators. They've been open. Any door I want to go into, I can get into, and I can usually find a legislator there to talk to, but it's been an open process. They asked

me what I could handle, where I could handle it. You know, I'm not ready to call a scorched earth. I'm not ready to say that the sky is falling because we're a long way from it. It still needs full House approval. We had a lot of testimony on the draft release of the budget by House Finance. They had two-and-a-half days, and I want to tell you that probably 75% of it was related to the Department (indiscernible - background noise). Good input, but I think a realization as well that, you know, the old days aren't here anymore and that, you know, we need to look at saving (indiscernible - background noise). Can I find $25 million? I don't know. I don't know if that's going to happen in the next year. Do I think it's an insurmountable challenge to overcome? No. I don't. I think it can be overcome. Is there potential for pain? Yes. But you know, if our partners continue to step up as they've stepped up and we continue to increase the number of Native folks that are receiving care within the Native system, we're going to do, you know, a whole lot better because that just returns 50 cents for every dollar spent to that deficit that we have.

So I remain optimistic, and you know, I say, you know, continue to let the process work. We aren't gas and oil. We're seen as a boulder, an anchor, if you will, to the budget because -- anchor, not in a good sense to the budget, an anchor as pulling the budget down, and we continue to go, but

we submit at a very conservative one percent growth increment, and you know, I just say to people, I say, go back and find the last time a one percent growth increment has come out of this department. And so I will continue to fight for the $25 million. I ask that for the $25 million. I ask that you'll give advice to me as to how we overcome this obstacle. I'm happy to take it, but it's -- we're a long way from panic phase at this point, and if it goes forward, we figure out how we deal with it. So thank you. Questions, comments on either area?

COMMISSIONER ERICKSON: Before you take questions, could you ask if that's Pat Bank on the phone?

COMMISSIONER STREUR: Is this Pat Bank on the phone? Pat, are you on the phone?

MADAM COURT REPORTER: If you could just remind them to please put their phones on mute, that would be awesome.

COMMISSIONER STREUR: For those on the phone, would you please mute your phones, if they are not currently muted? Thank you.

MADAM COURT REPORTER: Thank you.

COMMISSIONER STREUR: In that case, thank you.

CHAIR HURLBURT: Thank you very much, Commissioner Streur. And Bill will be with us tomorrow again as well, and I think, today as your schedule allows. We want to go ahead and move on.

The major item for discussion of this meeting will be the All-Payer Claims Database Study that we have discussed before in our last regular meeting in October. We now have the final copy of that from Freedman, and we have -- Linda Green is here with us. Amy Lishko was going to come, but needed to stay in Boston and so is on the phone with us. So if everybody else could keep their phones muted, but Amy, if you could open yours up, and we welcome you, and we'll turn it over to you.

MS. GREEN: Good morning, this is Linda Green. I'm delighted to be here in Alaska again. I came to see you in October where Amy and I presented the findings from our stakeholder interviews and focus groups. Today -- hey.

MS. LISHKO: Thanks.

MS. GREEN: We completed our report. Sorry. Somebody, I think, needs to put their phone on mute. Okay. Thank you.

We completed the final report for this project, which Deb has put into the binder for you, and I wanted to be.....

COMMISSIONER ERICKSON: Excuse me, please. Could you also mention that it's available on the website now, for the March 2013 meeting page?

MS. GREEN: Thank you, Deb. And today, I'm going to provide a summary and recap of our report. On the phone with me is Amy Lishko, and I believe my colleagues at Freedman Healthcare are on the line as well. So if you have any questions on broader issues, please feel free to ask them, and

one of us will be able to answer for you.

So today, I'm going to give you a summary of the project. I'd like to discuss Health System Data and APCDs, which we talked about in October, just a quick summary of that. Options for informed decision making. We'll do a little compare and contrast for you. And later on today, we'll have another segment on transparency options. So this morning's presentation will take a break after compare and contrast.

So we wanted to just align this presentation with your core strategies for cost containment and quality improvement. These are on the summary that is also available online and in your binders. The new ones, I believe, are the last two. No. The first -- there were two new ones that we added.

COMMISSIONER ERICKSON: End-of-Life Care and Engaging Employers.

MS. GREEN: So since this list was contained in our October presentation, the Commission has added End-of-Life Care and Engaging Employers to Improve Health Plans and Employee Wellness. Still resonating through this presentation are ensuring the best available evidence is used for decision making, increasing price and quality transparency, paying for value, enhancing quality and efficiency of care on the front end, increasing the -- this is the End-of-Life -- dignity and quality of care for seriously and terminally ill patients, focusing on prevention, and building the foundation of a

sustainable healthcare system.

The goals of this project were to understand the healthcare delivery data and reporting environment in Alaska and where gaps exist. We wanted to understand how an APCD or other data solution would integrate with Alaska's current data initiatives. Were there other options for creating the data resources that are needed to meet the analytic goals that were on Commissioner Streur's bubble chart? Were there -- we wanted to assess stakeholder readiness and provide recommendations for the options that might meet your needs.

We did our work, here in Alaska, in October of last year. We conducted stakeholder interviews and focus groups. We reviewed existing healthcare data collection strategies and options. We obtained feedback from you at the October meeting. We developed your options for you, based on that feedback, and we're here to review those with you today.

So one of the questions that we wanted to make sure we laid out well for you was how APCDs support health system transformation. APCDs collect data from payers. So we have information about services rendered in all settings of care, inpatient, outpatient, pharmacy. We have a longitudinal look at service utilization. We can align the data by patient and look at the course of services rendered over time.

The data that can emerge from this APCD effort can be used to help consumers choose high value care, high quality

care, the best price for their needs. The data that emerges from this project could also provide data for benchmarking and other measures for policy and program interventions. There is an opportunity to use this data to better understand population health status. There is an opportunity to build analytic capacity for all health policy decision makers, whether in the public health side or the healthcare -- understanding healthcare costs, and there is an opportunity to provide data for clinical quality improvement. So it's important to recognize that the A.P.C.D is a mechanism that can support many different types of data and analytics, not just one.

COMMISSIONER CAMPBELL: Do you to take questions now as you go along or do you want to wait until the end?

MS. GREEN: That's fine with me.

COMMISSIONER CAMPBELL: Well, I have one. On your Project Goals, you look at access for stakeholder readiness. I wondered if you found a real willingness to participate as a goal by -- when you went through, doing all your stakeholder interviews?

MS. GREEN: Thank you. That's a great question and a very important one for us to understand through this project. We will go into that in a little more detail. We did find a variety of concerns, and we'll go through those.

So in our work with other states, we found some examples

of APCD reporting and analysis. Freedman Healthcare is currently working with Colorado, Massachusetts, Rhode Island, and Connecticut to help them build or use APCD data, and it's remarkable how different they all are. So New Hampshire has the New Hampshire Healthcare Cost Information website that many consider the starting point for APCD consumer reporting. It offers consumers a way to look up the cost of a particular procedure at a particular facility, the estimated cost based upon claims data. Maine uses the data for health -- for state employee health benefit design. Vermont has health care report card. Minnesota uses it for provider peer comparisons, and ultimately, to drive change in the way care is delivered. Massachusetts uses it for cost trends, not on a slide. Utah uses it for population health analysis, and Colorado is using the data to drive some market information changes, using the data not only for population health analysis, but to look at the effects of different models of payment and healthcare reform.

So to your question, what did we learn from our focus group and interview process? We heard about ongoing efforts to align Alaska's health data systems. As Commissioner Streur mentioned, there is a real interest in having those islands of healthcare data aligned and interactive. There -- we also heard a high desire for data-driven decision making. We heard kind of a frustration that there wasn't more information

available to decision makers about the state, as a whole. We heard often -- and it's good for us to hear -- that Alaska is not like the Lower 48, that there are unique geographical challenges here. There are heavily urban areas. There are areas that have access to the road system, and there are very, very remote areas as well, making healthcare delivery a challenge. We did hear -- and I think this was just echoed -- that there is beginning efforts to implement broad-based healthcare data collection and analysis. And finally, we heard that any data is an important first step for driving change.

We heard about the data system and information resources that are currently implemented or underway in Alaska, and I wanted to run through them quickly because they underlie some of the opportunities for further development.

So we know that there are national data sets out there. There is Census data. The American Community Survey. There are other surveys that are done with some federal support, like the Behavioral Health Risk Factor Surveillance System and the Medical Expenditure Profiles Study, which is called MEPS. There are partial views of what's going on. There is health plan data. It's available through MarketScan or the Health Care Cost Institute. There is Hospital Performance information reported to Leapfrog. And then there are the state data sets. There is Hospital Discharge data, which is

not entirely complete at this point. There is the IBIS system, which has the Behavioral Health Risk Factor Surveillance System data, and is planning to include the Hospital Inpatient Discharge data going forward, the historical records that -- I think it was 2005 to 2009 are the numbers I remember. And future plans are underway for Medicaid data and reporting.

What we did here is that this is something of a patchwork, that there was good information about some areas and not such good detail in other areas, and it felt like there needed to be a more comprehensive, a more unified, a more integrated look at what is really happening with healthcare delivery.

So we -- from these conversations, we gleaned something of a wish list for healthcare data, sort of what we heard compared to the data that's currently available. What we heard most was information about the health status of all Alaskans, not subsets. We heard also a need to understand healthcare costs and utilization trends. We heard a need to understand how cost shifting occurs among different payers, among and between, I should say. We heard a need for standardized benchmarks across payers and populations, how -- who is doing what, how does it differ from one payer to another, one public -- public versus private areas, populations. We heard support for consumer choice, based on

quality and cost. This is not unusual. This is a challenge every state faces. You're not different in that one. We heard that there was a desire to know about forgone healthcare due to access or cost, another difficult challenge and another one that is shared by your colleagues in other states. We also heard an interest in information about consumer satisfaction. Where is that going to come from? As I'll talk a little bit later, Leapfrog data, hospital consumer surveys conducted by Medicare, they're not complete. There is not data on every facility in Alaska. So where are we going to get that data from? And then clinical outcomes, how could we get more information about that?

So given this wish list and what we've learned so far, we talked to you in October, and we heard some themes loud and clear, in addition to the ones that we had already heard in our interviews and focus groups. We heard that cost drivers need to be monitored on an ongoing basis, that it's not enough to have long-ago data. It needs to be reasonably timely. We heard that stakeholders are getting ready to consider new data collection and analytic strategies. I would say that there is, perhaps, not uniform -- there was not uniform support around the table, but there was an openness to considering what the opportunities were and what the advantages might be.

We heard that integrated care systems, Indian Health and the Air Force, are actively using health data collection and

analysis to improve care and manage cost. There was some lively discussion about that, very interesting for us to hear.

We heard that there was an interest in linking findings from data and analytics directly to cost savings. I think it was -- well, I won't name names, but I remember having a conversation where I was asked, well, what's the return on investment on an (indiscernible - background noise) data collection strategy, how will we know that it's really made a difference?

And we heard emerging interest in how cost transparency could have a positive impact on the Alaska healthcare market, which was also -- you know, we also heard a great concern about the potential for having a negative impact on the Alaska healthcare market. So all great feedback.

So who could use more data, you know, overall, based on what we heard and what we've learned since then? So consumers. What's the best value for a consumer in light of higher co-pays and deductibles? What's the out-of-pocket? How are small business -- small group plans in small group markets changing the deductible and co-pay structure in order to keep those policies affordable?

We also know that consumers need to be engaged, increasingly engaged in care, and this is a very tough piece. How do we present that data to them in a way that's going to help them make those choices?

In terms of providers, what could they do with more data? Well, definitely, best practices, finding models, finding who is doing a great job in finding those opportunities for expansion of what those providers are doing. We want to be able to understand differences in healthcare utilization across settings, assessing readmissions from one hospital to another -- key in this healthcare environment -- and clinical quality improvement support, understanding what happens when -- in the trajectory of a patient's care.

For employers, self-insured employers, how can they find and steer their employees to getting the best care at the lowest cost? Small businesses, again, that consumer and employer interaction, helping the employers find affordable products. And for policy and decision makers -- probably, I'm preaching to the choir, to some extent -- getting a view into health system activity, examining the effective health policy changes, having a reliable, agreed upon, centralized source of information, being able to say, all right, we're all using the same numbers here. Now let's make some decisions.

And finally, views of cross-payer, cross-provider activity over time. That's the public and private opportunities.

So when we had all that in mind, we felt that there were, really, four sort of big categories of options for collecting data and creating reports and analysis, and I put them on this

continuum to show, really, how they move along in terms of complexity, and really, completeness, how far does each one take us towards information of a real portrait of the entire healthcare system.

So Option 1 is repurposing existing data, and I'll talk about each of these in detail. Option 2 is a distributive model, Option 3, a limited geographic model, based only on commercial data, and Option 4 is the All-Payer Claims Database that we've been talking about. We felt it was important to look at different ways to try to get the data that might be desired here. We really sat down and talked about, well, okay, are there any other ways that we can help Alaska develop a portrait of healthcare system performance, health status, consumer -- provide data for consumer engagement on the way to an All-Payer Claims Database and so that is the theme of this section. Can we get there without doing -- going all the way to an APCD?

So Option 1, Repurposing Existing Data. So this is the first step on the continuum, and we wanted to say, all right, we know there is a lot of data out there already. The Feds collect some data. The State collects some data. What could we do with it? So we sort of started with a little inventory. What's out there now? So there is Hospital Compare. There is the American Community Survey, Kaiser State Health Facts. There is IBIS. There is Hospital Discharge Data.

Now, we know that these have limitations. We'll talk about those in a minute, but we want to just layout, okay, these are the sources that you could use. We would compile that data in a standardized format, and we would present probably this information in a report form. This is not so much a database, but it's a way of taking what we have, creating sort of a benchmarks report.

An example of this kind of report is what Massachusetts called the Key Indicators report. They simply repackaged other data, put it out once a quarter, updated it with whatever was new, and used it to report on their Healthcare Reform bill. The Commonwealth Fund is a local scorecard. I believe that's annually. The California Health Foundation does this annually as well.

So you have a common set of information. We'd all understand it; we could talk about it. Putting this report together, probably three to four months the first time. Updating it annually thereafter, you know, a month, two months because you'd have all the formats done.

So what are the strengths and limitations of doing this? Well, so most important, there are no surprises. Everybody has seen this data. It's been publicly released. It does not require vetting, in a sense. It's -- the federal surveys, the state data -- the format may be different, but there is no extensive data quality checking process that's needed. There

are no privacy issues. The data is available at an aggregate level. Easy downloads. No extensive data processing required. Spreadsheets will be fine to manage this data. They're short, these mini data sets from Hospital Compare.

So in other words, the level of effort to do this is relatively small compared to an IT processing or some sort of data intake process.

The limitations? It's going to be fragmented. We're still not going to have a total view of health system activity. We won't have information about everyone in Alaska. We won't have regional drill downs, or really, any customized reports. We will be missing data because we know that Leapfrog has only a couple hospitals in it. Hospital Compare has missing data about many of the hospitals. The survey data is -- you have to remember -- self-reported. So, health status is a person's opinion of their health status. It's something. So this satisfies our need to have something, but it gets us, really, just on to the pathway.

The last point is a little inside baseball, but for those of you who know about federal and other studies, the methodologies change from year-to-year and so trend analysis is sometimes off. It may not be an issue for the larger group, but I wanted to note that as something that we've encountered that has been quite frustrating. Any questions about this? I'll move on. Please let me know if you have

questions.

So Option 2, a distributive model. Okay. What do I mean by that? Well, this would be a more complex effort where we would request data sets, perhaps once a year, from health plans, from Medicaid. Get Medicare data, too -- go out and ask TRICARE, Indian Health Service, Veterans Administration, work with them to get their data, do a once-a-year de-identified data collection. We'd have a large volume of data. We'd still need to come up with a place to put it all. We'd have to have some business intelligence tools. Similar models -- MarketScan, Health Care Cost Institute -- they take this data in, de-identify it, put out cost reports, and do annual trends, start to do some utilization analysis. It really is a good start. Time from start to the first report, probably about 12 months. That's what the Health Care Cost Institutes seem to need for theirs. It could be less. I don't want to over-promise.

So what are the strengths for doing something like this? Well, it could be voluntary. The health plans don't necessarily have to be required to do it. It would take negotiation, but it could be done because the -- if it's de-identified and if the State is willing to forego some other data elements that might identify the payer, for example, there would be some opportunity for negotiation there. It's, again, not regulatory. There would be a small number of key

commercial plans, which is one way that Alaska has an advantage of other states because you have only the four major commercial payers. The potential for data from federal entities. It would support payment reform analysis. There would be an opportunity to examine how payments -- where the costs are and how they vary. There is an opportunity to build a record of successful data use by the entity that is managing this process. De-identified data mitigates any privacy issues, and the annual data submission process is a smaller ask on your payers than a quarterly or a monthly file, like other APCDs, the formal, full-blown APCDs.

So having said that, what are the limitations? The voluntary data submission could vary in quality and format, and this can be difficult to resolve on the back end. The advantage of a standardized format allows you to take the data in, do some data quality analysis, and understand what you're working with. There is no transformation of the data that would be required if a format was established. It's possible that, in the negotiation process, it could be that the health plans would agree to do that. Again, open question.

Self-insured data, much less likely to be obtained. We haven't seen a whole lot of voluntary self-insured data sharing in other states. There will be a limited longitudinal analysis possible of a patient's use of care over time. The de-identification means that we will not be able to look

across payers. So if someone has insurance for a while and then goes -- obtains Medicaid or some other subsidized assistance and then pops back into the commercial world again, we won't be able to follow that person.

The uses of the data, too -- and this is an important piece of the negotiation. The uses of the data will be established during the data use agreement process with the health plans. It's likely that the permission to use the data will be somewhat -- could be somewhat limited by the health plans' concerns.

So we've stepped onto the continuum now and so now we're into a more rigorous model. We're going to call it the Limited Geographic Model. This came out of our conversations that -- and points raised here at the Health Care Commission meeting in October that, really, consumers in only the most urban areas of the state have a choice of providers, and we heard that providers in the more less densely populated areas are usually solo practice sorts of arrangements and that quality comparisons or cost comparisons might not be as appropriate or as important because they have -- really, a patient has a limited choice.

So with that thought in mind, we said, well, perhaps the right approach could be to limit an APCD to the major urban areas where consumers have a choice. So in that case, we'd focus on commercial and third-party administrator data. We'd

be able to do analysis of care patterns, utilization trends and costs, provider outcomes, pretty much, you know, a good and thorough look at what's going on for those densely populated areas.

We'd recommend using statutory authority to require commercial carriers to submit the files in a standard format. This really sets a good baseline for data quality efforts. We feel that this could build on work that's already underway for the new MMIS Data Warehouse and be able to leverage those resources for data storage and data manipulation.

So examples of data -- APCD type databases that have done this include regional collaboratives, the Puget Sound Collective in Washington State, for example, the Pacific Business Group on Health. There are also initiatives going on. One's going on in Cincinnati right now that's kind of a regional Cincinnati for a three-state area voluntary APCD type database underway. So there is a precedent for doing this around a particular geographic area. The time from the start to the first report, we're calling this 18 to 22 months. This includes getting the legislative authority, getting a vendor onboard to do the data collection, and making sure, then, the data is in good shape, that what we're collecting actually looks like what we think is going on out there.

Strengths and limitations of a Limited Geographic APCD Well, we get most of the state's population, 80%. You know,

we can really do some really thoughtful drill downs for those areas. In terms of reporting -- another kind of inside issue for those of you who have done data -- health care data analysis, we don't have a small cell size issue in the less populated areas. Not only do we avoid identifying a single provider, but we also don't risk having a lot of "not able to reports" due to a small number of patients or observations in a particular category. We really have a more compact area, and we think there may be an opportunity to kind of expand the analysis to other areas of the state using statistical models. I think this would be something that you'd need to work, but it is an opportunity.

So what are the limitations? Well, it's pretty similar to what you'd have to do for a full APCD Still have to get the legislation, do the rules, get a vendor, do all the work on the data. We don't have, then, the full insight on the health status of the population for the entire state, which is a need that I heard expressed.

There are limited comparisons between an urban area and the residents' local health care options in less populated parts of the state. So we know that there is a lot of travel to the major urban areas for more complex healthcare, but there may not be an opportunity to really compare, if we exclude residents of more far-flung areas from this analysis.

And finally, the Medicaid Data Warehouse goals may not

align with this project. We -- I think the Medicaid Data Warehouse project is still underway, and it's not clear where this would come in, if these two projects were aligned. Any questions?

So Option 4, a full-blown APCD and all the way out on our arrow. It creates -- as we've been discussing and describing to you, it's a robust data source for advanced analytics about healthcare across the state. It really supports the broadest range of analysis and reporting for policy development and research, health system transformation. You know, I'm wary of making something sound like the best invention since sliced bread, but I do think there is a great deal of data opportunity here to move the data into different formats to extract different profiles, to use it in ways that are going to offer new opportunities to the broadest range of healthcare system users in this state. I'll go into some of the uses in a minute, but the legislative authority establishing an APCD really gives the strongest possible framework for data intake, and we emphasize that something this complex probably should happen under legislative authority. It's too complicated. It has too many moving parts to proceed voluntarily at this full-blown level.

The data sources. The commercial payers submit periodic files in a standard format. State agencies contribute Medicaid, vital statistics data, could contribute other

information. I have one state that wants to try to align this with days missed from school for kids. So you know, think big. Medicare data is available from CMS at a very low cost. You can work with other state agencies, other federal agencies for completing the portrait of healthcare cost and utilization in this state.

You have a lot of examples to build on at this point. There are over a dozen APCDs in operation. A lot of lessons learned. Small states. Big states. We have the regional collaboratives to build on. So you have something to start with.

So what's the -- I listed the states for you, Colorado, Oregon, Utah, New Hampshire, the New England states. Delaware is interested. I'm hearing reports from Montana, New Mexico. Really, everybody is starting to think about how are we going to know whether we are on the right track or not and that really seems to be a theme, and they seem to be going for the APCD level of data. I have not heard of Limited Geographic. I've not heard about Distributive Models, other than the regional collaboratives. I haven't heard a state level Distributive Model. Yeah?

COMMISSIONER ERICKSON: I'll comment on that just real quickly, too. I just wanted -- I thought I'd mention for the group, too, along those lines, that, just this past month, 25 states -- Alaska was not one of the applicants, but 25 states

just received a State Innovations Grant Award that would fund something that the Commission had recommended last year, which is multi-payer payment reform initiatives, and I noticed -- I didn't go through each project to review, but I noticed a number of those projects included funding. We'll use some of the -- I think each state was going to get $2 million over the course of two years -- will be using the State Innovations funding to develop new All-Payer Claims Databases. So there seems to be a trend and interest in using some federal support and interest on the part of federal government and supporting development, too.

MS. GREEN: I would say there is also interest in APCDs in states that have chosen not to engage in developing exchanges on their own. Florida has typically been very, very interested. There is, as I mentioned, a few others, but I was thinking, especially, about Florida, how they came to the party recently on Medicaid expansion, and yet, they have really moved forward with thinking carefully about an APCD. Their first step was to issue a request for information to understand what the market would bring them in terms of a vendor and how much it would cost and timing and what kind of reporting they could expect to get out of it. So you know, that could be a very viable, you know, next step for them.

So in terms of timeline, we've called it 16 to 24 months. We've seen it take a lot longer, but the most engaged states

seem to be moving in this time range. I'm thinking, particularly, of Colorado, which passed its legislation in August of 2011 and launched its website on November 1st, 2012. Could that be? No. It must have been 2010. Connecticut passed their legislation in May of last year, and they are probably going to be starting their work later this year on data collection. I think they're going to get there. You know, some states, not there. Not there. It took Rhode Island a lot longer. So they passed that law in 2008, and they have the first step of vendors onboard, but they are still working on their regulatory approach. So that's a little bit opposite. Usually, we see the states getting their regulations in place and then the vendors. Rhode Island is different.

So what are the strengths of an APCD? Well, we've talked about some of these. It's the most complete source of information in one place. We know that your commercial carriers are familiar with APCD submission processes in other states. We know that it can accommodate Medicare and Medicaid data sources. We know that you would be leading the nation and working with federal agencies that have not yet submitted data to APCDs, such as the Veterans Administration. And we know that an APCD is that credible, single source of state-specific information.

And we've already talked about some of the limitations.

The development schedule for an APCD is extended, and you may need to be moving faster on some of your health system transformation systems, given budget cuts, given your priorities that you set out for yourself. So it's important to think about, can we make certain decisions now and wait for our data to come along? But we felt we had to put that out there.

We see that there is, you know, some management and development effort that's going to need a multi-year commitment of energy and resources. We usually see that, at least, one person makes this their full-time job over the course of the development process, even if vendors are hired to run the IT part.

There will be a need to engage your healthcare community in data-driven decision making and helping everybody understand what this data is going to tell them, how it's going to be used, setting ground rules for when something will be reported and when it won't be reported. You know, there are HIPAA ground rules on data release. You have to have a certain minimum number of observations in a cell, can't report people by age over the age of 80, I believe. There are zip code restrictions on HIPAA reporting, only three-digit zip codes or grouped in areas with 20,000 people or more.

But there are also other ground rules. There is the "no surprises" ground rule. We will always release data --

release reports and metrics privately to any named entity prior to a public report. We might also have a ground rule that there is an opportunity to review requests for data, should the APCD decide to provide data to researchers. Let's put those requests up there. Let's have a multi-stakeholder committee review the requests for when the data is used. So these ground rules help set, at the beginning -- or at least, discussed in the beginning, help create an environment that everybody knows there is going to be a chance to weigh in, that there is no heavy-handed "this is what it is," that it's a collaborative process.

The other concern we had was how the Medicaid Data Warehouse, again, might affect a joint effort. There are priorities that Medicaid needs to achieve with its data warehouse. They have a great number of reporting requirements. And my observation in other states is that it's been a somewhat prickly relationship between other users and the Medicaid organizations. Sometimes, there is just not the bandwidth to make both things happen at once.

And data from federal agencies, other than Medicare, will require negotiation, and some work on the part of whoever becomes an APCD czar for the state. In addition, the short legislative session, here in Alaska, might add to your timeline. That's a factor that we really couldn't build in. Other states seem to be in session slightly longer, so there

is more time to get it done. Whether that produces better results, I will remain silent, but again, if you have one shot a year and only a few months, there may be a longer timeline.

On the other hand, you know -- I shouldn't "you know." On the other hand, that might give more time to build the collaborative relationship that are needed to help everyone understand what's going to go into the APCD and what might come out, how this data is going to be used. Help develop the environment and the climate for the stakeholder engagement. you know, this one is a double-sided limitation. It might -- it might not be all bad if there is actually more time prior to a legislative effort.

So what are the similarities and differences among these options? So I want it to be quite clear there are gaps. There is no uninsured data. We haven't found a way to get patient-level, non-hospital, uninsured data into these APCDs. Maine tried something with a card that captured that information. They've had medium success with that.

We won't know about forgone healthcare due to access issues or cost. You know, we won't really have any sense of whether someone delayed getting care because they couldn't either get to the facility or because they didn't feel there was the right provider that they could use in their geographic area. We don't have a great deal of information about consumer satisfaction in an APCD or any other model that we've

talked about so far. I think that's a very interesting piece because we really haven't thought about social media yet in terms of healthcare. Those of you who get these newsletters may have seen one this week that social media -- the "likes" for a hospital are tracking the more formal survey data from Hospital Compare, which I thought was -- I really want to see this tested more. Could we use Facebook, for Heaven's sake, to get ourselves some information about consumer satisfaction?

Another entity called Castlight uses consumer satisfaction data gleaned from the "likes" for different providers as one of the elements on their "information about a provider" page. When a consumer -- it's a consumer-facing website that says, you could get this care and here's what you could expect to pay. It's usually used by employers offering self-insured care and trying to drive their employees to more cost-effective providers, but they also use the data from social -- they call it social media to add another data point to the consumer selection. So I want to plant that seed as well.

We don't have a whole lot on clinical outcomes in APCDs yet. There is -- oh, there has been a desire to align APCDs and Health Information Exchanges to try to glean the lab results, to understand whether a person has had, like, nutritional counseling or smoking cessation counseling and then look at their healthcare costs and utilization subsequent

to that. Not quite there yet. A couple states are talking about actually leveraging their Health Information Exchange platforms for APCDs, which I think is a very interesting opportunity. Maine is working on aligning it. They have some grant funding to do that. So there is another potential there, but it's still in the beginning stages.

So the differences among these different options is the level of detail. We talked about could we do drill downs, could we satisfy everyone's needs. We talked about comprehensiveness. Do we have a picture of the whole state? Do we have the ability to meet needs for policy makers, consumers, providers, employers? Can we do the kinds of regional analysis that we want? Would the different stakeholder communities find this information valuable? We talked about -- we will talk about the level of investment and the operational issues, but there are significant differences among those, and of course, the cost. So let's drill down into those a little bit.

We looked at each of the four options on a set of criteria. The first one was Analytic Needs. The second is Level of Effort to Overcome Barriers, and the third is Estimated Cost. So we align this chart in the same framework as the options on the arrow. So Option 1, the least complicated. Option 4, the All-Payer Claims Database.

So how well does each one of these support the analytic

needs that we've heard? And really, it does go from low to high in the same order that the options move. Option 1, the really low opportunity for using -- for doing extended analysis. You get the statewide level. We have incomplete hospital discharge data. The other data is too aggregated to really do anything, drill down with it.

The Distributive Model, Option 2. Well, there, we get a little -- we add on some value here. We have more information. We can get more granular detail. We can do some drill downs. We can start to meet more of the policy, consumer, provider, and employer information needs, but we will have some limitations due to the voluntary data submission process. We may not have conforming data. We may not have every data element that we want because it will be the product of a negotiation.

Option 3, Limited Geographic Model. High, much higher with the exception that we will only have the major urban areas. There will be ongoing trend analysis. There will be an ability to drill down into subgroups within that 80% of the population. Won't be able to do as much of the consumer piece as we had heard about because there will not be information in the outlying areas. There's a balance.

Option 4, we've talked about that. High drill down. Meets all four categories needs for health trends, policy analysis, some utilization, and some health status.

Were there any questions about Support of Analytic Needs?

So the barriers. What are the barriers to actually getting this data? We've touched on them. I wanted to organize it a little bit and show you. There is -- none of this is easy. I will say, if it were easy, you would have done it already.

For Option 1, there is still getting some need for trying to align these different data sources. They -- there are some data sources that don't quite mesh. So there really won't be a comprehensive portrait here, but most of the data is available on a download. Leapfrog you have to pay for. If we went with some other data sources, we'd probably have some small licensing fees.

Distributive. You've got to negotiate those agreements with the health plans, and there will be some negotiations with the Feds for their data.

Limited Geographic. Recommend legislative action. Assure privacy controls, which imposes some level of work on your team. Resources. Understanding the use of the data, the stakeholder engagement process, and federal data negotiations.

Really, that's the same for Option 4, the Limited Geographic and the All-Payer Claims Database. They have the same set of barriers.

COMMISSIONER PUCKETT: I just have a question that goes back to the analytic needs.

MS. GREEN: Yes?

COMMISSIONER PUCKETT: Can a commercial data warehouse.....

COMMISSIONER ERICKSON: Oh, wait. Excuse me, Jim. You have to use your mic.

COMMISSIONER PUCKETT: Can a commercial data warehouse pull reports from an APCD that they could use to run some analytical work for one of their customers?

MS. GREEN: That's a great question, and the answer is, it depends. It depends on whether the stakeholder engagement and conversation process has established that as one of the potential uses for the APCD. Some states say, never going to leave the state for any other purpose than research and analysis that we, the state, does -- do or one of our agencies or one of -- or a contractor under our direction. Other places say the data is out there. It's a research tool. As long as you follow our data management protocols and use the data in a way that's consistent with our legislative authority and stated uses in our Data Release Policy, then you can have it.

And then there is a third point on the spectrum, which is, if you can pay for the data, you can have it. You may not get everything you want, but really much broader sense of the data use.

I think that there is a sense, in some places, that the

data should be free. It's not -- and not free in terms of dollars, but to get the data out there in approved ways, you know, whether it's HIPAA consistent or consistent with making sure that the market is protected, but still using this data to improve market efficiency. I think that those are principles that want to be established right up front and are an important part of getting that stakeholder involvement that I mentioned as, perhaps, one of the advantages of having a longer timeline up front. I see those things as being important predecessors to actually starting any data collection. We see a couple of states stumble when they haven't had the opportunity to really get that clear. What is the data going to be used for? And without that, it makes it very difficult for anybody to say, well, I think it's a good idea. You really need to have that conversation in a very thorough way.

So the options also carry different costs, and our assumptions on these range from low to high. We have seen the very low end happen in state agencies that have established collection, data analysts, you know, that are experienced using large data sets. We know a couple of states have very robust Hospital Discharge data collection systems, and they've been able to build on those to start doing APCD data collection in-house. And in fact, the data collection, once it's built and underway, probably not all that expensive. It

takes some effort to design the intake models and to get the rules straight, but once it's there, it kind of chugs along. It's really the next stage. What are you going to do with the data? What kinds of reports? Are they going to be on a Web facing portal? Are we going to have consumer-friendly or is this going to be a very straightforward sort of website, like the New Hampshire Health Cost Compare, which is no graphics, no color, just put in your health plan and you get back some numbers? So that's what it counts for these ranges.

So, Repurposing Existing Data. You know, start out maybe $150,000. This is to design everything and get your graphics reports underway. Then Year 1 Operations, we've got $60,000 and $175,000. It depends on, you know, how complex you want to go with the reports, how much graphics, how much color. So for a range of $210,000 to $325,000 for some very good-looking reprints of federal and state data. So in my opinion, they're least useful, and the relative strength for your purposes is low.

Option 2, Distributive Model. So here, the range is $550,000 to a little over $1 million and somewhat more useful. You could really start to get there. The high end assumes that you're going to have to contract all of this out, that there are very few in-house state resources that are available to do this, and you know, we see not only the data intake here, but the management process of getting the data clean and

compared across any benchmarks. And then if a data release process is going to occur, if any one of your state researchers is going to use the data, you have to set that up as well. So it's not just touching data here. It's also policy and procedure and that's built in here as well.

Limited Geographic Model, Option 3. We saw this as $595,000 to $900,000 because there would be as much legal work to do. We'd have the statute. We have regulations, but we wouldn't have one-on-one legal agreements to negotiate with the health plans. And you know, a lot more useful.

And All-Payer Claims Database with the full-blown getting everything, we thought $995,000 to $1.5 million because you'd really be able to drill very deep into that and do a lot more reporting. These are ballpark and could be higher, could be lower.

So summary of all of these. Well, as you think about these different options, we heard that, you know, the data gaps limit the choices and options for the policymakers -- you -- providers, payers, and consumers. We heard that the reports and analysis produced from an APCD meet more of these needs than any other option, and we see a need for a resource to provide detailed and unbiased information for cost transparency initiatives. We think that you could go far with some of these data options. We see that an APCD is probably going to get you more of the way than any of the others. So

with that, let me take questions.

CHAIR HURLBURT: Can I start with one, Linda? You've talked about the cost issues there, which are a significant factor as we heard in the earlier presentation. What is your experience with the states that you know of and that you have worked with as far as the source of the funding, from General Funds, from fee structures? What have those states done that have implemented or are implementing an All-Payer Claims Database or one of the other options as far as the source of the funding?

MS. GREEN: Great question. So some of the states, the early states did this with General Appropriations. The next wave was to realize that, if they use their Medicaid data infrastructure, they could provide a service to Medicaid, such as reporting in analytics with the tools that were implemented for the APCD, and so were able to use some of the federal reimbursement for Medicaid IT to support the APCD.

The next round were the Health Insurance Exchanges, which several states were remarkably successfully in getting $6 million as part of their Insurance Exchange. I believe New York State got even more than that. Connecticut and Rhode Island got $6 million each.

And then the latest wave is the SIM grants that Deb mentioned, the State Innovation Model grants, which give states the opportunity to create a measurement structure for

the effects of these new health transformation models that they're implementing. And then they have an opportunity to go on and request model testing funds, which would probably include some APCD funding as well.

Another option is to get private funding. Colorado got no state appropriation at all, and they had to go out to their private health foundations, which really came through for them, did a fabulous job of getting them the startup funding. Their long-term plan is to really market this data and use it in ways that, again, advance the goals of health care transformation in Colorado, but also to use a commercial fee scale for it.

COMMISSIONER DAVIDSON: So can you translate that to -- all of the things that you just said to our state? So for example, one of the states, you said, used Health Information Exchange funds. Are you talking about the Exchange Plan funds that were made available to states?

MS. GREEN: The Health Insurance Exchange dollars to set up the Exchanges, Level 2 Establishment grants. There is also one state that's talking about using their Health Information Infrastructure. They have not figured out how they're going to do that yet, but they want to explore that as a way to do that, that alignment between clinical data and APCD claims data.

COMMISSIONER DAVIDSON: So the reality is, in our state,

that's not an option because Alaska has chosen not to participate in those Exchange Plan grants, so that's off the table. So really, we shouldn't even be talking about that as an opportunity in Alaska because that opportunity has come and gone.

In terms of using federal Medicaid dollars, as I understand, all of those dollars are currently being used and allocated for the MMIS system, which is a process that has been -- that redesign and rebuild has been going on for years and so I don't -- yeah (affirmative). I know -- it's been going on since before I started at the Alaska Native Tribal Health Consortium, and I've been at ANTHC for seven years. And so those dollars are off the table.

So of the remaining dollars, it sounds like either billing insurers who will, of course, assumingly, presumably pass those on to consumers who will see those in increase premiums, or perhaps, seeing those trying to get appropriations from the Legislature during a time when they just cut -- we heard earlier today -- $85 million out of the Health and Social Services budget. So I guess I'm wondering, where that leaves us in terms of Alaska and opportunities? Given our current environment, what do you think -- where do you think our realistic opportunities are?

MS. GREEN: I think the Medicaid Data Warehouse is -- you know, it's not moving as fast as you wish, I'm hearing. I

think there is a real opportunity there though because it creates a data infrastructure, a storage -- a way to store and retrieve claims information and extract data. There would need to be add-ons for the business intelligence tools that would be required. I'm not -- I have not seen yet where they're going to go with that, but the new generation of data warehouses typically have a business intelligence layer.

COMMISSIONER ERICKSON: Just one point of clarification, too, in terms of the Medicaid IT data. Paul Cartland, our State Health Information Technology Coordinator, was going to be with us today, but got called back to a meeting back East, but he's been talking to some of his colleagues, other State Medicaid Health IT Coordinators, about their use of the data, and they update -- we've provided a link on Commissioner Streur's last slide to the State's Health Information Technology Plans. So you can see the original HIT plan and then all of the subsequent updates, including the one that was just approved by the Feds last week. And so there still -- there might be an opportunity, still, to work in some resources through the Medicaid/HIT process, and we can follow-up with Paul on that and get you that information.

MS. GREEN: I do also want to say that CMS is very supportive of APCDs. They haven't gone as far as to offer money directly for APCDs. We're all waiting for that, but their willingness to fund them through the Health Insurance

Exchange grants, their support for Medicare data sets coming into APCDs, the Qualified Entity programs allowing states -- specific organizations to use Medicare data and combine it with other claims data, these all clearly recognize that you need the data from somewhere, and I think the entire healthcare reform process -- there is no other way to measure it. So I would look to CMS over the next few years to increase its support, and I think that, going through the Medicaid route, may be the way to go because they have, you know, an established funds flow there.

COMMISSIONER DAVIDSON: Except that we've certainly heard a lot over the last few days and certainly last week, in very public ways, our state being very reluctant to rely upon federal resources that may be available initially, but may not be available over the long-term. So I'm assuming, if that concern is true in those other instances, it certainly must be a consideration in this instance as well.

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: Thank you. And thank you, Linda, for your thoughtful presentation. I want to explore a little deeper this notion of All-Payer, if we could. There may be more than a nuance there. As far as we can tell, because we don't have any complete data sets, about half the population, about 350,000 people have any kind of commercial coverage, and some large portion of that is through TPAs and self-funded and

through national employers who are headquartered elsewhere. So I'd like to hear what your thoughts are about the third-party administrators, the non-three carriers that you talked about, as well as employers who are domiciled someplace else and then just to dig farther into this, the federal pieces of this. I mean, it sounded like a lot of cooperation required to get the (indiscernible - voice lowered), to get TRICARE, which are big, big chunks of our population. Federal employee plan is 25,000-plus people here. The tribal has not been mentioned, at least as far as I heard. And without really understanding the probability of bringing those data sources in, do we really have an All-Payer data set or really just another subset of the whole? Thank you.

MS. GREEN: Great questions, Jeff. Thank you. So on the federal -- the ones that are federally controlled -- let me start there -- there seems to be -- and I've had this conversation with some of the national APCD folks. It seems like the other state agencies are kind of sitting back and waiting to see how far CMS is going to go. CMS, Centers for Medicare and Medicaid Services, understands that these data sets that you mentioned, federal, TRICARE, Veterans, are -- have just not -- they just haven't ever been asked before. So there is some work in Oregon to get some of the, I think, Indian Health Service data, some of the -- I think they're getting Veterans. They're in negotiations to get that, and I

think we will have to kind of wait and see. Just as providers here and payers have not been asked to share data before, these federal agencies have not been asked either. So I think we're in a new era. I think that it will emerge. It's not there yet.

In terms of -- sorry?

(Pause - background noise)

COMMISSIONER ERICKSON: See if Pat's on the line.

COMMISSIONER BRANCO: I apologize. This is Pat Branco, and I'm just mentioning to Ward that I have my hand raised. When it's opportune for me to ask a question, just say my name.

CHAIR HURLBURT: You'll be next, Pat. Thanks.

MS. GREEN: Jeff's second question was about third-party administrators. That is treated differently in every state. So in some states, there has been legislation to require third-party administrators to submit data to the state APCD. It's been challenged in Vermont and Maine, and the Federal District Court has upheld the state's right to obtain this data. It's -- the issue is that ERISA can't be preempted by any state law, and the courts found that the state had a legitimate interest in understanding what was being paid and that this did not regulate the business of the third-party administrator. It's important to get express legal authority, statutory authority to do this. The voluntary approach is not

plausible for third-party data in one state. We've had a couple of self-insured entities come forward and tell their TPAs, we want to give our data to the state APCD, and the TPA said, we can't, and here's why and has a set of reasons that really cannot be budged without legislation.

COMMISSIONER DAVIS: By employers -- the national employers or international, like BP, Conoco, (indiscernible - away from mic).

MS. GREEN: So if the -- it depends on how -- if the employer is using a TPA or a national carrier, usually, the law is written to require it for all residents of the state to be submitted. It is a -- it has to be written carefully in order to do that.

CHAIR HURLBURT: Pat, please? Welcome.

COMMISSIONER BRANCO: Thanks very much, and I apologize for my absence, and again, it's probably limited time that I'm going to be available to join the call, but thanks for the opportunity to ask a couple of questions.

But first, I want to comment quickly on Jeff's previous statement regarding, quote, All-Payer when we have some folks that may or may not participate in the future, and I appreciate the answer we got. One area of concern is whether the data will end up so watered down that it's virtually unusable. (Indiscernible - phone interference) critical access hospitals to DOD/VA hospitals, (indiscernible - phone

interference) IHS, and we're not all playing with the same level, identifying the same population of care, cost, and quality, do we really have adequate averages that we can address? That's just a comment, just one more piece on Jeff's point.

So I do have other questions, and the first one is regarding the potential use of the data. And so when an APCD is built, would it be possible to profile the income of an individual private provider, be it a physician in private practice or a hospital/clinic, et cetera? That's one question.

And so the parallel is, what information was (indiscernible - phone interference) as proprietary, if any, in these systems? And I'm going on mute, so any background noise doesn't bother.

MS. GREEN: Hi, Pat. This is Linda. The -- your question is very similar to a restriction that Medicare uses on reporting their data, where no provider's name can typically be revealed, particularly if the amount of Medicare reimbursements can be derived from the data that's reported. So for example, you can't report the number of encounters for a particular procedure and the average cost or reimbursement for those because we cannot derive the amount in any way.

I think that your question is, really, how will the data be used and how will we make sure that the data is used

fairly? And that is a two-part process. Number one is to have the conversation about the analytic uses of the data up front to set some principles about what's fair and what's not fair. It's not so much the nitty-gritty rules, but what do we want to achieve with the data that is reported out?

The second way that we handle this is to create a diverse stakeholder committee to review all the Data Release Requests. So when the data is in, it does not go anywhere until this release committee reviews a formal application for release by an outside entity. What I often here is, we want to make sure the data is not misused or that something is reported correctly.

So this committee would not allow -- excuse me -- this committee this would approve an application for data use from an organization that has the capacity to perform an accurate analysis and for a purpose that is consistent with the legislative and regulatory purposes that have been established.

In terms of how the State would use the data, there would also be principles for what kinds of reports the State would release and that would be discussed up front as well.

In terms of proprietary information, the APCDs in other states report the charges the patient paid, the plan paid, and the total allowed amount. The purpose of this is to be able to create some sort of average or median price for consumer-

focused reporting or for state analysis. Some payers have argued that the allowed amount is a proprietary piece of information, and there, we say, often, that this is information that's been provided on the Explanation of Benefits back to the member. So it is, in some senses, not private in that regard.

Again, let's go back to the uses of the data, however. The point is not to put out there who pays how much to whom for purposes of revealing contracts. It is to allow individuals to make better decisions about cost-effective care and to allow analysis for the healthcare system.

CHAIR HURLBURT: Pat, did you have another question or was that it? I think Allen and.....

COMMISSIONER BRANCO: Sorry. I'm on mute. And no; I didn't have a follow-up. I really appreciate the answer, Linda. Thank you.

CHAIR HURLBURT: Sure. Thank you, Pat, for being on. I think Allen has one and Keith and then I'd like to have one question. We may run just a little bit over, but I think this is kind of the central focus. Allen?

COMMISSIONER HIPPLER: Thank you for your presentation. I have a question about strengths and weaknesses in slide 21. You say that it's -- a strength is that we have an opportunity to lead the nation. Sadly, my own prejudices make me think that, whenever anybody says Alaska has the opportunity to lead

the nation, is not desirable. Why is that a strength? Why wouldn't it be better to just copy exactly what New Hampshire, for example, has as opposed to trying to do something ourselves? Why do you consider that a strength?

MS. GREEN: I consider it a strength because I believe that innovation is good, and I believe -- and what I have learned about Alaska is that there are so many different subgroups that would not be counted on traditional claims that, to meet the express desire for an overview of population status, Alaska is going to have go out there and be a national leader and advocate for the release of data from these federal agencies. There are other states that want to do this, too. There are other states that have significant military populations, other states that have no information about veterans, other states that have many federal employees about whom they have no data at all. So you could lead the nation. You could join -- you could lead a coalition of other states, which has proven to be very effective and is why states can now get the Medicare data.

There was a concerted action by the National APCD Council last year to go to CMS, to present to them. There must have been half-a-dozen different ways that states could get Medicare data, all of them in silos, not able -- you're not able to even ask to reuse the data for a different purpose. Everybody got the idea, okay, this data was granted for the

purpose of care management or for the Advanced Practice Project, but CMS was originally saying, and you can't reuse it, even if you have it in your data warehouse and you have it organized and cleaned. With the efforts of, I think it was, over a dozen states, CMS came forward and created a new process for Medicare data, and they're allowing multiple uses on it. They're even thinking that way on this Qualified Entity Process now, where they're making Qualified Entities really jump through hoops to become certified to use this data, but they are, at last, saying, and if you have another use for the data now that you have it, we will consider that as well. So the answer is they're coming along. CMS is coming along. The other federal agencies will come along, too. They're waiting to see how far CMS will go.

COMMISSIONER CAMPBELL: I am having a hard time wrapping my arm around the ultimate goal of transparency, which is for a consumer to compare apples-to-apples, institution-to-institution, provider-to-provider; am I right in my definition of transparency?

But I think what you talked about here was aggregating the data so it was, quote, transparent, but you can't get to that level of detail, at least under your explanation that I heard or understood. If -- I'm going to compare Dr. Urata to Dr. Stinson, for the like thing. If it's aggregated into a big pool someplace, quote, it's transparent at one level, but

it isn't on the individual level, so that a patient can come in and say, oh, these guys practice really identical medicine, and I think I'll get the same quality in place, but Dr. Urata is 15 cents cheaper and I think I'll go there. Will we ever get there with this kind of data set?

CHAIR HURLBURT: And before you answer -- because that's exactly where I was going, Keith, and maybe I'll put it in a different context.

COMMISSIONER CAMPBELL: Ask it better, please.

CHAIR HURLBURT: And in my mind, I'm thinking of Colorado because there was so much in the media, enthusiastically in the *Denver Post* and whatnot, when they started theirs last year. But if you or your spouse needs a coronary artery bypass graft or a hysterectomy or whatever and you have a significant co-insurance and co-pay exposure or you're either in ERISA or you're a fully insured payer -- and pick Colorado, pick one of the other states -- with you, as that individual, and perhaps another individual as the payer, what difference does that make? And I'll use the example -- for example, when Commissioner Hultberg from the Department of Administration was testifying about some of the things that Jim is looking at and doing with his program there in Juneau, she commented that her husband needed some kind of a procedure -- she didn't say what -- and they looked to see where was the best place to go, and she said a one percent mortality rate or a three percent

mortality rate may not sound like it's a huge difference, but it was a huge difference to us, when they were looking at quality outcomes. So both cost and quality. If you are the individual -- bring it down from global. You, as either the individual patient and the individual payer, what difference does it make?

MS. GREEN: What I hear is that it's the intersection between cost and quality that will make the difference to a consumer, and you're absolutely right. Most of the consumer-facing websites only look at cost or they look only at quality. The triple aim, really, is to bring those two together and have patient experience in there as well.

So the APCD data or a large aggregate database can do that. It can help an organization provide the data that can be reported in terms of cost and quality. So you could bring in your Vital Statistics records and get the mortality. There is also federal reporting on that, on just Medicare though. And there are other quality measures that can be developed out of the data. It's how it's presented. It's how engaged consumers feel about these decisions, whether they feel they're capable of making decisions. So there is a learning curve there as well.

What we've seen historically about healthcare is that patients don't really have much say or much interest in how much it costs. Amy Lishko, my colleague on the phone, can

talk about the lack of consumer engagement. Amy, can you talk to that?

MS. LISHKO: Yeah (affirmative). I mean, the evidence, the research evidence has shown that people haven't, by and large, used this information, but (indiscernible - phone interference) you know, we don't know evidence of some of the circular arguments that the data and information hasn't been there and so the plans that will necessitate people shopping haven't really taken hold in many states. Is that because the data isn't there and so -- you know, no one really knows.

So I think, in the future, there is going to be greater demand for this information. As Dr. Hurlburt mentioned, as more people have higher out-of-pocket costs who do need to shop around, I think there will be a need for a better, more integrated website that has both this quality and cost data available.

COMMISSIONER ERICKSON: Thank you, Amy. In the interest of time and in an observation, I think we've segued into the conversation on transparency that we have scheduled on our agenda for this afternoon. So for those of you who want to continue this conversation, if you could make a note to yourself about where you want to pick up, and with apologies, I'm going to suggest we take our break now because we have quite a few panelists lined up for sharing some of their insights and experiences on how they've been using health data

and what they see as current barriers and opportunities for the future around some other uses and then we'll continue with the transparency conversation this afternoon. Does that sound like a good plan? Why don't we try to take a ten-minute break? Dr. Hurlburt, does that sound good?

CHAIR HURLBURT: Yeah (affirmative). We'll start 10:20.

COMMISSIONER ERICKSON: We'll restart at 10:20. Thank you. And for those of you who are on the panel, if you wouldn't mind joining us at the far end of the table here as soon as you're ready, we'll get you set up there.

10:09:04

(Off record)

(On record)

10:19:53

CHAIR HURLBURT: If folks in the room here could gather around the table again? Okay. The next session that we have here, we have three different panels talking about health data and analytics, current uses, and the first one we have is Improving the Public's Health with Andrea Fenaughty who is the Deputy Section Chief for the Section of Chronic Disease and Health Promotion. Andrea, if you could go ahead?

MS. FENAUGHTY: Well, good morning. It's nice to see your faces again. I get to come back every now and then and talk to you guys, and thanks for inviting me and trying to get me to talk about something other than health data and how we

like to use it. So let's just get started. This will be pretty quick.

So just a real quick overview, I'm going to just really briefly touch on the different sources of data that we typically look at and then get to how we use the data, both directly and indirectly, so directly what we do in our program offices with the data to improve the public's health and then indirectly through our partners and the public. I'll talk a little bit about gaps and then some of the opportunities that we see coming.

So these are our sources that we tend to use for looking at burden of chronic disease and other health issues. From surveys with adults, we have the Behavioral Risk Factor Surveillance System. That gives us statewide, self-reported data on risk behaviors. For youth, we have the YRBS, Youth Risk Behavior Survey, which captures data on high school students across the state. PRAMS and CUBS, both are surveys of mothers, and PRAMS are looking women who have recently given birth and asked them about various risks associated with their new children. CUBS is a follow-up survey, asking about three-year olds. So we get risk behavior data, basically, from all those sources, self-reported.

Then under administrative records, we work with the Hospital Discharge data. I know you're all familiar with that. And also we do some analyses with Medicaid Claims

Registry Data. Currently, we really are limited to the Cancer Registry, which is in our offices, and the Trauma Registry, which we partner with, and then, of course, vital records. We tend to focus on cause of death. That's what we look at in our office often.

So how do we use the data? Sorry for the acronym. That's Chronic Disease Prevention and Health Promotion in our office. The first step is identifying the burden. How big is the problem? Just as an example, of course, adult weight status, we know, is a prominent issue, and here, you can see 27% of adults in Alaska are obese; two-thirds are overweight or obese. So just in terms of the extent of the problem, we use health data.

Also in terms of looking at trends, what's changing, getting worse, getting better? This is looking at high school smoking prevalence in Alaska from 37% in 1995, a pretty significant drop, and then it's continuing to come down to 14%.

We also look at issues of health equity. So do we see differences between Alaska Natives and non-Natives, Alaskans with lower or higher socioeconomic status, or region of the state?

This is some data from our Cancer Registry, where we actually get to see the stage of cancer, and of course, late stage is much more challenging in terms of positive outcomes.

Looking at the regions of the state, you can see quite a big difference between the more urban areas on the left-hand side in terms of late stage rates, and this is for colorectal cancer. And then on the right-hand side, you see some of the more remote areas, higher rates of late stage cancer. So that's identifying the burden.

The next step would be do something about it. So develop some kind of approach to address the burden. We start with strategic plans. We like to identify what it is that we're going to do going forward. And just as an example, our section came out with an integrated five-year plan just this past year, and one of the -- some of the data that we looked at was around hospitalizations because it isn't just chronic disease that we focus on, and we noticed that hospitalizations due to injuries that were due to falls were very high in the 65 and older population. In fact, I think it was about 80% of injuries to fall in that population among injuries and hospitalizations, and it was on the rise. So that was some pretty strong data that suggested we needed to do something about this, and it became one of the four goals of our strategic plans. So we're really focusing effort on four areas, and this is one of them. So of course, from there, we developed some strategies, and we're starting to implement those.

Develop strategic plans. Another thing is take up new

initiatives based on the data patterns that you see, and this is just an example of one, again, based on data that we had been monitoring for quite a period of time, seeing the stubborn tobacco use rates among Alaska Native adults not going down, where we were seeing progress in non-Natives. So we pulled together a group of tribal health experts, tobacco health experts from across the state over a period of a year to really sit down and intensively ask the hard questions about were there differences in programming, were there reasons that programs weren't reaching or were not as appropriate in some areas of the state. We came up with some recommendations, and we and our partners have started implementing those and were recently noted by some CDC experts as saying, you guys are doing stuff in disparities that no one else has figured out yet. So we really appreciate it, the work that we put into that.

Beyond identifying burden and then trying to do something about it, of course, you have to monitor. You have to keep collecting data to see if you're making progress. Is what you're doing effective? An easy way to do that is with a score card or a dashboard. Everybody loves a dashboard. You guys hear "MarketPlace" on the radio. Kai Ryssdal, the other day, said there is a sequestration dashboard now that they're going to be doing everyday.

This example is from Healthy Alaskans 2010 where we

pulled together -- looking at all the leading health indicators over the past ten years, and really quickly, if you'll look to the right-hand side, you see a bunch of red "X's". So at-a-glance, you can tell how you're doing. So that's definitely something monitoring progress in all of our efforts.

Now moving on to how our partners and the public can use health data. First of all, we provide data in many different forms. We still do some print. Of course, we're moving more and more to Web all the time. Much easier to update, revise the data that you have out there. We do still respond to some special requests. A community member or maybe a university person asks for specific data, we can do that. You've heard me talk before. That takes a significant amount of time. So what we're moving towards is this Informed Alaskans Initiative with the two components being Instant Atlas that you've heard me discuss before, the little screen shot of the map, so mapping health data across the state. That is currently live. I'll talk about it more in a second. And then the IBIS, which is the Indicator-Based Information System. Unfortunately, it's still not quite launched, and I'll talk about that in a minute, too, but obviously, we're moving in the direction of more Web-based data to get it out to everybody who wants it.

So, How the Partners Use the Data. Basically, to support local health assessments and then health improvement efforts

coming from those assessments. So I just picked a couple of examples. MatSu Health Foundation, of course, a very strong partner in this arena, and I just went out to their website, and I noticed, you know, one of the five strategic goals they have of their foundation is to monitor Healthy Alaskan and to make progress on that goal. So they, clearly, are focusing on health data and how to plug it into their health efforts.

Another example, the Southern Kenai Peninsula Group. This was a MAPP, —A-P-P. It's Mobilizing for Action through Partnerships and Planning. They put out this report in 2009, and I just grabbed a couple of -- it's filled with data, health data and other data. This is focusing on domestic violence-related events, and the bottom bullet, "Add these two for scope of the problem in our area -- roughly one reported everyday." And of course, this then translates into their priorities. One of their three priorities is addressing substance abuse and domestic violence, and of course, they have a series of strategies that they're already implementing, based on that.

How the Public Use the Data. I will say most of the information that we share really is aimed at partners, and through them maybe, the public, but we do have, increasingly, more public awareness campaigns. These are just some screen shots of a couple, hopefully, you're maybe a little familiar with, the "Get Out and Play Everyday" for childhood obesity

prevention and the “The Real Cost,” which is a program around tobacco prevention, showing the real costs to every Alaskan.

So moving over to gaps, the graphic is really to show that -- I think our strengths, in terms of looking and using health data are on the left hand, and on the right-hand side, I think we do a pretty good job of figuring out what the risks are to Alaskans, and we can measure if people have died, but that morbidity piece in the middle is much harder for us to get, and there’s a lot of important work that we could do there, if we could measure that better.

We do have Hospital Discharge data. I’m sure you’re aware of the issues with that. There really is, currently, no reliable reporting system coming from that data system, really due to capacity issues and the continuing issues of representativeness. We don’t have all the hospitals playing in that.

Registries are great. They give you much more depth of information than some of our other sources, but statewide, we only use the Cancer Registries, and there is a Trauma Registry. We’d love to have a Cardiovascular/Stroke Registry. There have been a lot of challenges getting those moving forward.

So on the horizon, IBIS again. It’s really been the security issues that have hampered that. It definitely is moving forward. It’s just been a slower slog than we had

hoped, and you hear all the cyber security issues in the news every week. So that's an understandable concern, but we are moving forward with that, starting again with our BRFSS, which is our adult risk behavior data, and you can see, down the line, we want to get to the Registries and having the Hospital Discharge data on that, which would alleviate the problem of the reporting that we've had.

Instant Atlas is the mapping program. That's up and running. We've got lots of data on there, BRFSS for now. We've moving to adding the Youth Behavior this spring. So that's exciting, and we're always trying to improve it. It's a little hard to use, so we're trying to make it a little more user-friendly. We're always up for feedback on that.

All-Payer Claims Database, I think you were just discussing this. It seems like a great opportunity to address some of the gaps that we have for what we try to do with data, get us access to the full scope of medical care delivered in Alaska as opposed to sort of the fragmented approach that we have now and what we're able to look at in terms of hospitals that may or may not be participating with the Hospital Discharge data or a system like the Medicaid data, which is really just based on eligibility.

It seems like these are the sort of questions we'd be interested in, the what, when, and where did some event or some illness happen, how much did it cost, and who paid for

what wasn't covered in terms of cost. And then I think the bottom two are really important. What are the influences that might impact an outcome in terms of co-morbidities or demographics? And what impact does preventative care have on an outcome? Those are really important questions for us to be able to answer.

In terms of the new MMIS, I guess I would say that, currently, we're not able to look at markers like BMI for weight status or blood pressure or cholesterol. If those were included, that would really be a benefit for us in terms of tracking our health outcomes.

In terms of HIE, I would just say that provider participation would have to be much more significant for this to be something that would allow us to track population health status, but there is potential there as well. And that's me in, I think, ten minutes.

CHAIR HURLBURT: Thank you, Andrea. Any questions? Thank you very much. Our next panel is Improving Health Plan Outcomes, Quality, and Cost and that will be Margaret Brodie, Director of Division of Health Care Services, where the Medicaid program lies, Jim Puckett, Director of Division of Retirement & Benefits for the State, where employee, non-unionized employee and retiree benefits is, and Jeff Davis, President of Premera and also President of the Health Insurers here. So I guess, from your various spots around the table,

Margaret, are you going to go first?

MS. BRODIE: I guess I can.

CHAIR HURLBURT: Please. Your name starts with “B” so you’re at the top of the alphabet.

MS. BRODIE: I’m Margaret Brodie. I’m the Director of Health Care Services.

MADAM COURT REPORTER: If you could talk more into the mic, that would really help. You can push it towards you.

MS. BRODIE: And what we do in Health Care Services is Medicaid and the Medicaid Management Information System. I’m pretty new to the job, but one of the things that I wanted to do right off is see if we can use our own data and try to determine how we can affect the health of Medicaid recipients, and it’s kind of new to our Division. They hadn’t done anything like that, so we started out with starting results-based accountability. And one of the first things that we did is -- do you remember that storm on September 4th, that huge windstorm that everybody lost power, trees went down? We took that to start to see, did that make a difference? Did hospitalizations increase? Did people’s respirators’ batteries die? I mean, what happened with the Medicaid population because of that power outage? And it’s not something where we can go, okay, next week, we’re just going to run it because people have a year to file their claims. So we’re tracking it over time, and we’re six months into it, and

we have actually found that the storm did not increase hospitalizations for Medicaid recipients. They were no significant cost increases in any category for that storm. So we thought that that was an interesting thing because we were pretty sure that costs were going to go up because of that storm. So that also tells us that the proper backup was in place for these people. So that was really interesting.

The other thing that we did is we actually took all of our Medicaid claims, and we looked at it for a couple different things, one for overutilization of the emergency room. How many people are going to the emergency room, and how many times are they going? And the other are -- and then taking that data and breaking it down to the people with chronic diseases, those that are using the emergency rooms as their primary care provider, and we found thousands across the state.

So the next step is, what are we going to do about that? We can't just -- we have Case Management Programs, and we have a Care Management Program. And normally, we put people, like that, into a Care Management Program, which is a lock-in program that people have heard about. So if they use an emergency room improperly, Medicaid doesn't pay for it. Well, that would affect every hospital in the state, if we pulled everybody into the Care Management. So we don't want to shift the costs off onto the private sector. So we're going to have

to manage how we do this. So we're going to start bringing people into the program slowly, but in looking at the data, the majority of the people had behavioral health issues and that's why they were over-utilizing the emergency rooms. So the state of Alaska isn't really set up to deal with that, so what are we going to do?

So two weeks ago, I talked with behavioral health providers in the state and told them, you know, this is what we're going to do. We need to do something with this population, and we're unsure of the next steps, and they came to us and said, well, why don't you have us case manage them because that's what we're supposed to do? And so we're in the very beginning steps of this, where we want them to -- and it's going to be next fiscal year, July -- afterwards. Just so you know, this is not tomorrow. So we want to hook them up with a primary care provider. We want to hook them up with a behavioral health provider and a pharmacy. And so -- and have them report back on exactly what savings are found from before Case Management to after Case Management. So we're going to be doing that over the next year.

We also -- we're going to pull in, before July, the top 20 emergency room users and pull them, hopefully, ask them to volunteer for Case Management, which isn't a locked-in program. So they just have a Case Manager, but if they don't volunteer for Case Management, we will be pulling them into

Care Management, where they won't have a choice. But we will -- even doing it within the state, we will be hooking them up with a behavioral health provider as well as a primary care provider.

Another thing that we've done with the results-based accountability is we're looking at where the providers are located around the state. We've never charted where all the providers and the different types of providers are located. We hadn't worked with public health to determine when they're sending out their public health nurses. So literally, we could be flying somebody from a village to come into town when the public health nurse is right there and could meet their needs. So we've been coordinating those efforts with public health.

One of the reasons why we're doing that is because the cost of transportation per year is $72 to $80 million for just the Medicaid program. So we're trying to look at efficiencies that we can find with transportation. We're trying to partner with other agencies to see, is there any savings that we could find? So I mean, I just started, but that's where we're at so far.

COMMISSIONER CAMPBELL: I almost forgot my question now. No. You're tracking all these people, and you're going to case manage it. Are you going to look at health status as a byproduct of your closely monitoring your pharmacy, your

providers, and that sort of thing?

MS. BRODIE: Yes. We are. That's part of the reporting requirements that we're going to require of any entity that's doing case management for us. It's not just the money. It's the better health outcomes.

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: How worried are you about the recent cuts to the behavioral health grants and impacting the ability of behavioral health providers throughout the state to be able to continue to provide that service? It sounds like you're going to be relying on them more, and they're going to actually have fewer resources to be able to do that.

MS. BRODIE: I can't speak to the exact behavioral health proposed cuts because that's not my division and that's improper. However, we did notify the behavioral health providers at the same thing that I was speaking at, and this is a way to re-infuse the behavioral health community because it will be using Medicaid funds rather than grant funds.

CHAIR HURLBURT: Dave?

COMMISSIONER MORGAN: For those on the Commission that have been around me for four or five years, I've been talking about what you're doing since, what, three years ago maybe, but not necessarily specific to that area. We know that 15% of our Medicaid population consumes about 85% of the resources. They're basically chronic. They're hitting the ER

rooms. This is the first time I've heard we've pulled numbers, we've found a major group, which is behavioral health. I'm assuming that's substance abuse and mental health, right? And you've tracked it to the ER and to the pharmacy. I, personally, think another group would be your diabetics and asthma. I don't know if you've had time to do that. It sounds like you're kind of rolling this into normal stuff. I feel your pain from doing that.

But the real question, in my mind, I like the idea of moving off grants into billing Medicaid and utilizing Medicaid funds because you actually then have outcomes you could track and chase and look at, and it will be interesting to see, at the end of this, if you have an actual effect on the utilization because, as one of my friends will say in a little bit, if you're making them healthier, they tend to use it less, most of the time. So I won't use that statement anymore today either.

What were your -- and another suggestion is I know the VA is really -- I wish our Colonel was here. The VA has been very helpful in the tribal sense, doing a contract with us on the primary care side, and I'm engaged, right now, on doing some home health with the VA, possibly here. Have you actually made an inquiry out to them on the same concept?

MS. BRODIE: We have not. We've been working with our tribal partners to start with.

CHAIR HURLBURT: The question I had, in identifying the frequent flyers and having the Case Management or Care Management, including behavioral health, are you also including MSW type (indiscernible - voice lowered) social service expertise in that, in looking at them and suggested interventions?

MS. BRODIE: That is part of what we're trying to figure out because we have to figure out what is appropriate for them to be able to bill Medicaid for.

CHAIR HURLBURT: I think my experience has been, even if you can't bill, that there are certain aspects of it where the expertise that you need, that really saves you money by improving care, are things that a social service social worker has to offer than a nurse, for example, doesn't have to offer. So as a part of the picture, even if it's not a billable service, it gets you to more optimal utilization and better outcomes. Any other questions? Thank you very much, Margaret. Next then, we'll go to Jim Puckett.

MR. PUCKETT: Good morning, I work with the Division of Retirement & Benefits, and the Department of Administration, and we administer two health plans. The Alaska Care Employee Plan has about, this year, 15,600 lives, and the Alaska Care Retiree Plan with about 61,500 lives. I should point out also that our retiree population, we're experiencing a net growth of about 1,500 members per year. We're processing more

retirement applications, but with the people that are passing away, we're experiencing a net growth of about 1,500 a year. Also you need to understand that 25%, or about 25,000, of our retiree population, is in the Lower 48. So they're part of our expense, obviously, but they're not in the state of Alaska.

Last year, we had a very good year. We only had about $560,000 million total expenses for the two plans. I hate to say that, but it has been worse in the past.

We've gone through the learning curve, like a lot of other folks, and especially you folks on the Commission, of knowing that we have a sea of data, but very little information, and with that little bit of information, we have even less knowledge. So we're going through that learning curve ourselves and trying to become more effective at actually managing our plans.

We've learned that data is just simply data, that you've got to be able to work with it wisely before it's of any value to you, and we also understand that, if we have -- if we're better informed and we have informed access to our data, that will help us make better decisions to improve the quality of care that our members are experiencing, and hopefully, to bend that trend across, going down a little bit, or at least, leveling out.

All of us have heard the phrase "mining the data." Well,

We've learned that, before we start picking and shoveling at the data, we better get a pretty good idea what we're looking for. You have to have a specific goal or region for the data report, and if you do, well then, you have a better chance of hitting the pay dirt.

The way we use our data, it's continually changing. It's evolving. We're asking ourselves, what do we need, what are we going to do with it, what's our goal, what do we hope to accomplish before we start digging in too deeply?

Currently, we know that we can identify trends in health claims, but we're still learning. We know we need to get better at governing the drivers that are producing those trends. We know that we need to improve our capabilities to drill down when a trend pops up. We rely on our vendor partners to help supply the data of our population and then we also rely on our Benefit Consultants to help us analyze, offer recommendations, and then help provide the decision support, if we are considering making any type of changes.

We're not focusing solely on them, but we're definitely taking a closer look at the 6% of our employee plan members who are 59% of our costs, and the 6% of our retiree plan members who are 48% of our costs. We recognize, if we can make even an insignificant impact in just that small part of our population, it could produce, you know, dramatic results in our costs.

We are already watching our utilization rate and our per unit cost. Those are pretty easy to gather from our aggregate data that we receive. Just from utilization rates, we've, a year ago, implemented -- I won't say it's a penalty, but an ER incentive, an incentive not to use the ER improperly. Now we haven't looked at the data to see if we've made an impact on that, but that's something that we've done recently.

We also incentivized our population to use their preventive services, an annual physical, for example. We looked at the data, and we saw what portion of our population had been using physical annuals, and now, we're at that point where we're ready to examine the data and see if our incentives have improved that, but right now, we don't know exactly how that's going.

We've looked at data to track our drug spend. We've looked at it to see what type of adherence rate are our members with doctors' prescriptions. Are they actually following the doctors' instructions on that? We were very pleased to see that, based on comparison with other state health plans, our members had a very, very high adherence to what the doctors prescribed for them to do.

We've also looked at our generic usage to see what kind of percentage that our retirees have for that, and we're pleased that, compared to many other state retirement health plans, we have a very good adherence rate. We're working at

getting information out to improve that, but we were pleased to see that we're doing pretty good already. We expect to have a recognition that we need to become better at the data in order to manage our health plans to improve outcomes.

Some future considerations that we are looking at or some future challenges are we realize that we need to look at our data from an enterprise-wide perspective as well as just our Alaska care health plans' perspective. We know that we need to identify a relationship between certain medical conditions and other needs that that person may have. For example, if we have an employee that is suddenly using quite a bit of FEMLA leave, it's possible they're probably going to need some employee assistance program services a little later in their FEMLA. We're just trying to be a little more proactive when we see things, like that, pop up, if we have employees that have a Workman's Comp injury, that may lead to other services, that might be admitted somewhere in the state for short-term disability or if they need to have some accommodation for them to return to work, things of that nature.

Other future considerations we're looking at is we know we need to have some training for claims data analytics and also for some data analysts internally. We've learned that Alaska Care owns the data, and we needed to make the changes in, for example, our RFP, so that the data remains with us. The statute we have to change vendors every so often, and in

the past, apparently, it just wasn't that important to hang onto the data. Well, now, we know we've got to have it in order for us to manage the health plan.

We're generally supportive of the All-Payer Claims Database, but we're like everybody else; who is going to pay the cost? So that's what we're looking at.

Some other future needs are we need internal and external support so that we can analyze the data widely, interpret the reports, and then also to provide the evidence that our decision makers need in order to make changes in the plan, as we adjust target provisions, as we respond to changes and best practices, and as we respond to changes in our populations. So that's what we've looked at over the last year-and-a-half and what we've got coming forward.

CHAIR HURLBURT: Sounds like a lot of real progress, Jim. Thank you. Any questions for Jim? For those of us who are not Premera employees, we probably think Jeff exists in data heaven, and so you'll probably tell us why you don't now, Jim. But anyway, from the health plan perspective, if you could share with us the resources you have and how you use them to improve the health of the folks that you insure or administer?

MR. DAVIS: Sure. Thank you for this opportunity, and I wanted to move from that seat to this seat on purpose because I believe, when I sit in that seat, I represent all Alaskans, even though I come from a payer perspective, and I usually say

that in the introduction. I thought I might spare everyone that this morning, but I'm saying it again now. But here, at this point, I'm going to represent payer perspective, and specifically, Premera Blue Cross because that's what I know about. With respect to that seat, I'm still undecided about the value of an All-Payer Claims Database. From this seat, we really see little utility, and I'll explain what that is.

Just a little bit about Premera Blue Cross, one of 19 Blue Cross Blue Shield entities in the country. We serve 1.8 million people, primarily in Alaska and Washington, a few in Oregon, about $8 billion in revenue or premium equivalents, one percent bottom line. So as we talk about this, we talk about what we're doing to use data and other tools to reduce expenses by improving quality. It's not to improve our bottom line. We're a taxable non-profit, and everything we make goes back into the company to improve our ability to serve our members.

So sometimes as we talk about these things in perspective, particularly from some providers, is, well, you're just trying to, you know, line your pockets, and I am here to tell you that that is not the reason for this.

So I want to talk about three different buckets. The first is chronic disease, which consumes approximately 75% of all the dollars that we spend on health care in the country and about a third of that is -- or 25% of that is due to

lifestyle-related choices, primarily what we put in our mouths and how much we move.

So in that perspective, the data is already out there, and we know that, if you can get people to move more and consume things -- put things in their mouths -- that includes smoking and drinking and everything you put in your mouth -- that you can actually see a measurable decrease in the use of health care services quite quickly.

So there are a couple of ways to do that. One is we have a focus on work site wellness activities. It turns out that the work site is a pretty darn good place to create a culture of wellness, but it takes a lot of effort to do that. So we have a program that's actually pretty forward-thinking in the small group market for a number of years, and we continue to evolve that. We made changes last July to actually pay people to get their biometrics done and to do a self-reported health risk appraisal. We've seen great results with that. We also pay employers, through a reduction in premium, to encourage their people to do that. So it's funny how you get the wallet engaged, you can get some other engagement.

And towards that end then, sort of on the same part of the spectrum, is engagement of people in their own health behaviors. So it kind of gets to -- it crosses from wellness into transparency, so I'll go there. But as we heard from John Torinus, the effect that putting a high deductible plan

into his own firm had was rather dramatic. And in fact, you see, when an employee moves from a lower deductible health plan to a higher deductible health plan, something in the neighborhood of about a 30% reduction in services that consumed. When we look at our own population, people who buy their own high deductible plan versus people in an employee sponsored plan that has a lower deductible, the difference is about 38% with no difference in health outcomes. So there is a lot of this that's about us, which, I mean, gets to the next piece of this, which is transparency.

So if I'm going to be an informed consumer because now I have a stake in it, how do I choose? As part of the Blue Cross Blue Shield Association, we cover 100 million Americans and that gives us a pretty sizeable database. In fact, one of the biggest databases in the world is the database that is controlled by the Association, and through that and through the economies of scale that are created, we've actually been able to create a tool that's rolling out on our website where -- you know, and we've talked about costs a lot. You know, it's not just what's your price for something, but what's the cost per case. You know, as we look at -- read the article in *Time*, and acetaminophen costs, you know, $1.50, but that's just one little piece of it. So we've -- our database is organized around episodes of care by provider with a social media component to it, so people can go in and actually

report, you know, liked this doctor, didn't like this doctor and think that that gives some meaningful consumer information.

We've also created a tool that allows consumers to go in and say, for this thing for me, what is my out-of-pocket going to be, because, in many cases, that's what people are concerned about, not the whole episode of care, but what's their out-of-pocket going to be, so they can make comparisons that way.

We've rolled out mobile apps to do this. It's on our Premera website, and we think it's just really -- we've moved a long ways, but there is a lot farther to go, but the innovation that's occurring and cost -- it's really cost transparency. It's not quality transparency, except for the social media part, but the innovation is remarkable.

Moving to kind of the third bucket is waste, and waste in healthcare is defined as something that's done or provided that has no positive impact on the outcome, and in fact, may have a negative impact. Centers for Disease Control, Dartmouth Atlas, a number of sources say waste is, at least, 30% out of all the dollars we spend. So a trillion dollars out of $3 trillion we spend are things that do not add to quality and probably do a significant amount of harm. So we are working with our provider partners, particularly in the primary care area, to say, how can -- what kinds of things can

we do that provide better visibility to the primary care doctor, what's happening with people who attribute to them up and down the line, so that the waste can be eliminated? What can we provide in terms of real-time information? Your patient was admitted to the hospital last night or your patient was at the ER yesterday or those sorts of things. What can we provide that's actionable and real-time? And working with provider partners, what can we -- what are we willing to pay to do additionally, because it saves money overall and results in higher quality outcomes because we've eliminated waste?

So some of you may know there is a lot of stuff going on in the market right now, and some of it's not very popular with our provider partners, that we're doing, but we can all agree that a trillion dollars worth of waste is a pretty significant opportunity, and what we can do to drive that out is good for everyone.

So when we think about an All-Payer Claims Database, there are a couple of things that concern us, and it's based largely on our experience with the Puget Sound Health Alliance. That is, we already have the data. We already mine the data. We do it in real-time for us as we use it, and we act on it with programs that we've developed. So adding an All-Payer Database, now we have another place that we have (indiscernible - voice lowered). I'm not saying this, you

know, can't be done. I'm just saying from, again, the payer perspective, not that seat. Another place we have to report, there is a data lag that's significant. There are other things that we'll be able to see, but you know, does it drive out waste? Does it have to do with chronic disease? You know, if it's not in one of those three buckets, it's probably, you know, got limited utilities. Transparency, we've already got that nailed.

So we have to ask for it, receive it later, and then have significant discussions about, well, why does this number look different than our number, because it's really hard to compare, often times, because of the way data is aggregated. So those are some of the concerns.

I do want to just add -- not a shameless plug, but I'm on -- for full disclosure -- the Board of the Alaska eHealth Network, which has been presented here. We've heard about that and just had -- this is forward-thinking. We just had a discussion yesterday with our health actuaries and our actual analytics people, which is another point I'll get back to. It appears that, in the HIE, Health Information Exchange, there will be available to -- this is based on a national standard -- a packet of information that could be potentially available to payers, again, real-time that our people are really excited about. So we started discussions with Rebecca Madison yesterday about is that possible, when would it come, how

would we pay for it. That really got our team excited because of the potential utility of the things that we don't have access to otherwise.

So finally, just thinking about the All-Payer Database and the utility -- the usefulness of the information, we have an army of people who do what I just described to you, and most of them are health actuaries. And when I say an army, there are probably a couple of dozen actuaries in the company that are looking at this stuff, along with physicians and nurses who are saying, now, what do we do about it? We're doing this work full-time. So it's a little hard to imagine, without that, you have data, rather than information, and you don't know what to do with it, and are we -- you know, if we make the investment -- kind of sitting in that chair -- are we going to have data, are we going to have information, and are we willing to make the investment in people to get it from data to information that actionable? So thank you.

CHAIR HURLBURT: Thank you, Jeff. That was very interesting. Any questions for Jeff? Val?

COMMISSIONER DAVIDSON: So you mentioned the opportunity at the eHealth Network. Would that provide similar data to what the All-Payer Claims Database would do or is it similar enough for it to be useful and be done in lieu of an All-Payer Claims Database?

MR. DAVIS: There's probably some overlap, but it's more

-- my limited understanding of it is from being on the Board. I'm at 20,000 feet, and the people I was talking to yesterday wanted to know exactly what (indiscernible - voice lowered). The HIE is more clinical data and health status and demographic data than it is cost and utilization data, but the thing that -- they were so very excited about that because they were sources of data that don't have, and they need this kind of stuff to feed the engine to be able to say now we can do something that can help primarily on the "drive out waste" side and on the chronic disease side, but the thing that they were most excited about was that it was real-time.

So the patient was admitted to the hospital yesterday, not six months ago. Now you can do something about that. You know, make sure Dr. Urata knows his patient who attributes to him and then tell him or call him, and he knows his patient is in the hospital so he can make a follow-up appointment and follow that person to make sure that other things don't happen that shouldn't happen and come back in. It's that kind of real-time, you can do something about it need. Thanks.

CHAIR HURLBURT: Anything else? Yes, Bob?

COMMISSIONER URATA: Now you mentioned the Puget Sound Health Association and using data from there to gain information. Are you saying that some of the information from there could be applied to Alaska, and therefore, maybe we don't need an All-Payers Database?

MR. DAVIS: No. I was not suggesting that. Good question though. What I was trying to say is that the people that we had on the phone with Amy and Linda that was our direct experience with the Puget Sound Health Alliance, and in that particular case, we found that it made more work and had very, very limited utility coming back to us. There was nothing that, from the payer perspective, was useful. So again, from this chair, that's one opinion. From that chair, there may be a very different one.

CHAIR HURLBURT: Any other questions? Margaret, Jim, and Jeff, thank you very much. We have one more panel during this section. Mike Hirst, who is the Director of Data Services for SouthCentral Foundation is here, and I would say my experience has been that, in many ways, tribal health programs are kind of like an exemplary rural HMO in the way they have gathered population-based data, disease registries, and so on that have had real impacts on the clinical practice, which is what we're going to talk about now.

And then the second panelist will be Dr. Michael Acarregui, who is the new Chief Medical Officer with Providence Health & Services here in Alaska. Mike comes to that job from being with Children's at Providence, and his background is a pediatrician. And again, my experience has been that, of all clinical specialties, pediatricians are really the most clinical and population and community based,

in looking at why do the patients get sick and how can you prevent it.

So I think that Mike and Michael, we welcome you here, and we'll start with you, Mike, for the tribal health system.

MR. HIRST: Well, thank you, everybody. It's a pleasure to be here today. Again, I'm Mike Hirst. I'm the Director of Data Services at SouthCentral Foundation. I've been there for about the last six years doing that job. Prior to that, I've heard a lot of talk about the Department of Defense. I worked at the Population Health Support Division in San Antonio doing all the clinical performance measures for the entire EOD, so have a good sense of dealing with stuff on a large scale and also at a systems-based approach that we have at SouthCentral Foundation. So the challenges are the same. The scale is a little bit different; the challenges are the same.

I think, today, I would really just like to talk about -- and I think, Jeff, I don't know if you know this or not, but I was just, like, wow, is he just trying to set the stage for me or not, but really, we've really -- when I think about data, okay -- and it's really about information, taking data, turning it into information that we can gain knowledge from that we can take some action on. So, can you get it actionable?

So the fact that someone can tell us -- and this is kind of our philosophy. The fact that someone can tell us our

cervical cancer screening rate is 74% per organization, so what? What am I going to do with that? I'm going to make -- you know, is that good? Is it bad? Benchmarkable, I might be able to say we're going okay. But to really -- like Commissioner Streur said, you know, to make it actionable at the primary care level, you really need to get down to the identifiable information for each individual patient or customer in terminology that we use.

So what that means is not just not getting to a performance measure of an aggregate level of 74%, for example, but being able to say that each of the teams that are providing that care are performing at a level different level. So the score might be 74% for the organization, but we have variation. One might be 84%. We may have another one 63%. So we have some variation there. So the assumption that everybody is performing the same is kind of -- is false. And then the other piece of that is drilling down to the individual provider level, and we're very good about that as far as providing transparency where, when we display our performance metrics, we drill right down to the individual provider teams, and we display that information for the whole organization to see. We found we've had really good success in doing that. Like I said, for time purposes, we haven't showed you a bunch of slides, but we could show it to you, and you're invited to our Nuka Conference that we're having in

June. You can see more it, if you're interested.

The action piece of this is very important as well because, when we talk about performance metrics, typically, those are a subset of individuals from our overall population that we're looking at. So in other words, if I have someone who moves into Anchorage from an outlying village who needs care, for example, they may have only been with my health system for maybe a month. They may have diabetes. It may be a female who needs colorectal cancer screening or breast cancer screening and cervical cancer screening, right? She won't be in my performance metrics, and some people say, well, why isn't that the case? Because we really haven't really had an opportunity, at least from the provider standpoint, to intervene and have an opportunity to deliver some of that preventive care.

So when we look at those scores, they're not in my denominator for my score. However, they are immediately on an action list. So we have something that we call an action list. It's my name. Each provider has one. And the reason that we're able to do that is because we empanel. We think that's a very important piece. So patient-centered medical home, having customer owners/patients assigned to a provider builds a sense of responsibility. That provider doesn't necessarily have to deliver all the care, but they are responsible for the oversight of that specific care. So a

primary care doctor is not going to be doing the breast cancer screening, per se, but they will, hopefully, have a relationship with a customer/owner that they're dealing with and make the recommendation to get that, and we feel that's very important.

So impanelment is a very big piece that I want to stress here today, too. So working with the State, doing a lot of stuff around TCHEK (ph) is -- we're working a lot with that, too, and impanelment and patient-centered medical home has been very rewarding for us, and we thank you for the opportunity to do some of that.

What I find out with performance metrics, a lot, is that most of them, starting off, are very centered -- at least the initial ones that have been out there for a while are very adult or condition management-related. I think we're starting to see more children's metrics rolled into these, but I think that's an area nationally for opportunity. Other opportunities I see, too, are access to care. I see a lot of performance measures that are out there that are, in some sense, really not actionable. I'll give you an example. Access to care. Third next available. Everybody loves this "third next available," you know, around the point of availability. You know, how are we doing? We're going to benchmark against that.

Well, I've worked on the DOD side, and I can tell you

that they have a methodology where they will tell you it's based on the appointment type. Whether it's an acute, whether it's a routine, or whether it's a well visit, there is a "third next available" for it. And we do the "third next available" so we can benchmark because we think that's important, but really? The only one that we really, really care about is, now that we have an Electronic Health Record, I can look at the number of minutes that a provider has on a schedule every given day, and I don't care when their "third next available" appointment is because there is too much variation. The appointment might be ten minutes long. The appointment might be 15. It might be a half-an-hour, maybe an hour, depending on what your specialty is, right?

So it's more important for the clinics, when I interact with them, to know, what does your schedule look like today, tomorrow, a week? Thirty days out into advance is what we display, so I want to know what your schedule looks like and your availability is over a 30-day period now and into the future so that, if I'm a manager, I can actually react to that and say I know I should have this many number of minutes, not the number of appointments because you can really skew that, depending on when you're appointed or not.

So I think the lessons that we're learning are that there are a lot of great things for benchmarking and performance improvement that we have some regulatory requirements that we

report on, but I think it's also important for us to not lose sight of the action list, like we talked about, because of how important that is to delivering care as well.

One of the things I've noticed -- and I have this on the Department of Defense side, and I had it originally when I first came, too. A lot of people will ask us, well, who on the action list is part of my metrics? I'm very careful and have learned you don't tell them. You tell them, you know what, everybody on that list is important, and if you treat them appropriately, your score will go up.

Now, could they figure it? They could go through, and they could look at it, but they're too busy to do that. So I think that's a key piece as well because I see some new population health tools that are coming out that are trying to do some of this stuff, and they identify that, and I think that's wrong. I think you need to make sure that you treat customers and patients by what their needs are, not whether they're in a metric or not. If you do that right, then things will improve.

Where do I see the current state of things right now with EHRs? EHRs were supposed to be the panacea, supposed to solve everything, right? Electronic Health Records do a great job of collecting data. I don't know well they help us turn data into information, and I'll say the same thing about the iTools because I've seen this. I hear this a lot. I work with IT a

lot, and I hear a lot of, you know, excitement about the iTools, but the iTools are just an avenue for you to really get your hands on the data in a more reasonable way. The iTools aren't going to tell me who a diabetic is; somebody is going to have define what that is. It will give me access to the ICD-9s, the CPT codes, and all the other codes I need to look, but we're going to have to decide how we're going to define that and that gets lost a lot.

So what happens is a lot of people invest in their IT departments and say, hey, we need more money for IT, but they forget you need analysts to really use those tools and to set those up to be successful for you to use as an organization and that really gets lost in the budgets, typically.

What I see is a lot of things get appropriated for IT and not so much around what we call, like, a data services. I'm extremely lucky where I work because we've broken our Data Services Department. I do not work for IT. I'm an epidemiologist by trade, also a nurse, and have been around the block and doing 100 other things with information management. So when I got there, I was originally assigned to IT, and one of the very first things I said is, listen, I'm not IT. I said, you're trying to do these things. This isn't an IT function. So the organization was, I thought, very forward-thinking in breaking it out and letting me form my own department, and it's been very successful because, now, we've

established data governance, where we've established relationships and data stewards, where I have a direct relationship with the clinicians. So the Chief of Medicine and I have a direct communication; he's a data steward. I have an Operations Director who is a data steward. And what do I mean by that? Those are the people I go to, to find out what's important for me to report on. I don't need -- we don't need all the data in the world. We are not short on data. What we're short on is information. So what I tell people is, I can take, by interacting with the data stewards who are really responsible for what they're going to do with it, is -- with 20% of the data, I can answer 80% of the questions. My goal isn't to answer every question anybody is ever going to have. If they want that, then we can occasionally do an ad hoc. I want to make sure that I'm efficient, that I have the 20% on the regular basis that I can answer, the preventive medicine issues that are coming up. I'll just use the approach there. So you know, what are we doing to run smoking? What are we doing around cervical/breast cancer screenings? What are we doing around condition management with diabetes, hypertension, cardiovascular disease, those types of things? I don't need every piece of data in the world to address those things. So it really helps me to hone in on some of those. So that's very important as well.

The future. Where do I see the future going? I'm excited. I think we had a hard time with Health Information Exchanges and exchanging the data, even reporting to CMS. CMS, I know, has talked a lot about, well, we want you to submit data, but the problem that they're going to run into, and the problem that they have run into, is we do not have a standard nomenclature nationally that we're going to do reporting on.

We're using Cerner right now, which has its own code value system. So blood pressures is a very good example, right? So blood pressures, vitals, anything like that. Cerner has its own code value systems, and I bet you -- I think you all use EPIC, right? EPIC has its own code value systems, which are different than us, RPMS, which was the IHS once has, I think, called (indiscernible - voice lowered) factors, which were their own, little clinical events that they had built into it as well. So deal with this? You're going to have to use a national nomenclature, which I think 2014 is where they're moving, with SNOMED codes. Those old codes are going to have to be mapped back to a SNOMED code, and once you call it a national nomenclature, then you can, now you can submit your data to us after you've mapped it to that. That's going to require some effort. Who is going to do that? I don't know. They haven't come out and told us how that's going to happen, but they're going to require you to

have SNOMED codes and prescription norm codes, LOINC codes, CPTs, ICD-10 will all be out there. So just a handful of codes will help, but nobody thought about this when they talked about reporting. They just said EHRs are out there. So all we can really do now is a test, and if you ask the information systems how they're going to do that, they'll just say, well, we're just going to attest to our reporting right now because there isn't necessarily -- not all systems have SNOMED because it's built in. So until that happens, you're going to run into some problems. So that's forward-thinking, 2014. I think we've already been thinking about this two years ahead of it, two or three years before this even happened, and really trying to make sure that we're prepared for that as well.

The other thing that's exciting as well, but somewhat challenging, is, if you don't have a group, like a Data Services Department or somebody like that, that you've invested in, you're really at the mercy of your EHR vendors. Your EHR vendors will really rake you over the coals for a handful of performance measures that you have to do, and you know they're doing them for other organizations well, so economy of scale there, and if you really think about it, if you just got your EHR in the last year and you haven't back-loaded a lot of your historical data, even the data that you're reporting may not even be useful to begin with, and

you're going to pay hundreds of thousands of dollars to these vendors to do something that meets a requirement, checks your box, but isn't going to allow you to build the action list and everything else. So what we've really concerned ourselves with is not so much going with the vendor, but to use our own data warehouse to develop that and to move forward.

The federal government seems to be helpful in this, and so what we're looking at -- there is a program out there called Cypress, which the Office of National Coordinator for Health IT puts out, and it's a way for you to check your methodologies that you're running against so that you can get certified later in the future. So we're really working towards more of, how can we get ourselves certified to do some of this? We're not there yet. I think, over the next couple years, we're looking at trying to do that and not be so dependent on the vendors because, like I said, the vendors' focus is we'll charge you for the metrics. We'll charge you if you want to do that. So they're really not in tune, a lot, from a reporting piece around what we're doing, and I totally get why, and I'll wrap up with this. It's because, you know, when you think about, from the EHR vendors, what's an EHR cost? Tens of millions of dollars to get implemented. I know that's kind of the case around us. Tens of millions of dollars to implement it. What do you think a data warehouse costs? $300,000. Where is your focus? Your focus is around

the tens of millions of dollars, and they're going to make all the money they can on the EHRs. I'm not speaking for SouthCentral Foundation on this; this is me speaking. So I mean, they're going to make millions of dollars on the EHRs, and then once they've tapped that out, they're going to come back and worry about a data warehouse because now they've collected the data. So that's just my perception about how things are going to work, and I'm trying to stay ahead of the curve a little bit, and I hope the State will, too, on some of these things, try to stay ahead, try to think warehouse and how we can do things and not be so dependent on some of the EHRs that we've got and be a little more forward-thinking about -- maybe even collaborating and developing some training opportunities where people, like my group, can get together with some of the other groups because I know there is a need out there. I'm hearing it a lot, particularly from some of the Native villages that we work with closely that are, like, well, can you come out and help us do some of these things? So I think there is an opportunity there for us, through our Nuka Institute that we've got, that we would, I think, love to share some of the ways that we're doing things with everyone else and try to help you get out of that wedge that you feel with your EHR vendors. So that's all I have for right now. Any questions?

CHAIR HURLBURT: Thank you, Mike. Any questions for Mike

Hirst? Yeah (affirmative), David? Then Allen.

COMMISSIONER MORGAN: This is a softball question, okay? Don't bend it back. The -- you were talking about that 74% might be the average, say, on a cervical cancer whatever. The one the VA liked when we presented -- because we had to present all that -- was diabetes eye screens. But where do you -- if the average is 74 and you've got some groups at 63, some at two, and some at nine, what is the number that's the optimal threshold where you know you are making a -- improving the health or moving them to the plateau you want to get them to? Do you have a dotted line going across that this is where we want everyone to get to from some measure?

MR. HIRST: Yes. So the current measures that we use for benchmarking, at least from a clinical standpoint right now, are kind of HEDIS. Everybody -- I think there are a lot of people that do HEDIS measures. I won't say that they're all certified HEDIS measure people, but at least, it gives us a benchmark to work towards. So we strive more towards the -- so the minimum goal would be 50%. So the HEDIS 50th-percentile, working up to the 75%, is what we would say would be, like, our green, and if we were in the 90th-percentile, we'd think we were really, really achieving outstandingly.

Now why do I say we're not perfectly HEDIS? Because HEDIS will tell you that you need to subset your groups into Medicaid, Medicare, commercial, and to report on each of them

differently. Well, from a provider standpoint, they don't want three different lists. They just want to know how they're doing. So we benchmark against the Medicaid because we have a large proportion of Medicaid individuals and that's what we use as our benchmark. Is it 100% perfect compared to that because it's everyone? No, but it provides us an opportunity to benchmark against something. I think that we did that within the Department of Defense as well. We didn't break out each of them when we did that. We did every one as the same. And what really works out good is, if you do everything the same, then everyone gets treated the same. So I know some of the TCHEK measures that we submitted to the State, on a few them, our Medicaid population was doing better than the general population. So we don't distinguish between that with our action list and our metrics, and we think that's beneficial to our user population.

CHAIR HURLBURT: Allen?

COMMISSIONER HIPPLER: Thank you, Mr. Chairman. Mr. Hirst, it's a pleasure to listen to someone that's passionate about this work.

The Commission, in (indiscernible - voice lowered) was set up with a layman on the Commission who doesn't necessarily understand all of the terms that you use. I have a couple of clarification questions for you, to try to link certain parts of your presentation for that unnamed person. What is "third

next available?”

MR. HIRST: So when we talk about appointment availability, how well you’re doing around access to care, health care has developed a metric called “third next available.” That means, when is the third next available appointment in your clinic? Okay. Not necessarily by a provider, but within your clinic. So if you want to get access today or at some time -- so if you’re in a specialty clinic, for example, the first appointment might be today. The second appointment -- and then everything else is booked and then there is nothing else for another three or four days. On the second appointment, there happens to be an opening five days out. And then the third appointment available is seven or eight days out. Your third next available would be seven or eight days. So that’s what -- when I refer to the “third next available” appointment -- and you can see that can vary depending if you’re using 15-minute appointments, 30-minute appointments and that type of stuff. To me, it’s more beneficial to look at the minutes that a provider has available on any given day, and is it sufficient or it isn’t. It’s pretty simple.

COMMISSIONER HIPPLER: Mr. Chairman, just a couple more. Thank you. Thank you, sir. You spoke of an either “B,” as in bravo, one tool or “V,” as in Victor, one tool to extract data. Could you explain what that is?

MR. HIRST: Sure. Those were BIs, business intelligence tools. So yeah (affirmative). BI tools are business intelligence tools. Some of the ones that -- they're all over the place.

So I'll give you my example. Microsoft has a suite. They call it a BI suite, which would be where you would have reporting services. You would have (indiscernible - voice lowered) analysis services, and you have integration services, which basically take data and put it together to make it look really presentable. So the thing with business intelligence tools, they sell themselves to say, look at this; this is what your data can look like, and this is what you can do, and people spend a lot of money on those tools out of a box, but the tools don't tell you how to define diabetes. They don't tell you how to collect your data and structure it in a way to define it that makes it useful to you. When they present it to you, they've already done that, but they don't tell you, you have to do that. And so IT gets the money to buy the tool. It sits in the organization for a while, and if they haven't invested, like we talked about, in the analyst to help use the tool to make that -- turn that data into information that people can use, you've really just spent a bunch of money on a tool that nobody can really use. It's like you going to the Home Depot, if, you know, you're not a carpenter and buying, you know, a table saw, and you know, a great router

and everything else. The tools aren't going to solve your problem, if you don't have the people that know how to use them.

CHAIR HURLBURT: Any other questions? Yes, Allen?

COMMISSIONER HIPPLER: So this one's a little more inline with my expertise. You were discussing a possible scenario where, I believe, a medical professional could be evaluated on patient outcomes based on a certain population, and he would have a list of patients, some of which were in his metric populations; some were not, and you would not tell him which were? Is that correct?

MR. HIRST: That's correct. So the list that we give them -- so we do impanelment. So we have roughly 50,000 to 60,000 people that we serve in our local area. Those individuals are empaneled to a main provider, so you know who your provider is, okay? It could be a nurse practitioner. It could be a doc. It could be a PA. You know who they are. Yeah (affirmative); the impanelments change depending on what's going on, but you have between 1,000 and 1,500, roughly, people empaneled to each provider that they ever see, and it's actually the provider team. So those individuals, that provider team -- the nurse, case manager, the PA, the doc, whatever -- they're responsible for those 1,500 people from a metric standpoint. They don't necessarily deliver all the care for them, but they're responsible for following up on

that and ensuring that they give them reminders to -- because we feel that they have a relationship with them because they're empaneled to them, that the customers are more apt to have a relationship and follow through with some of those preventive services that we talked about. So they're not delivering mammography, for example. They probably are doing the cervical cancer screening, but there is the -- they get graded. Their teams get graded on well they're doing around those, based on those 1,500, 1,000 people that are empaneled to them, and then we display that and we show that to everyone about how well people are performing on the individual measures.

Now the action list, like I talked about, is all 1,500, but maybe you have 500 diabetics, right? Only maybe 450 of them will show up on your -- in your denominator because 50 of them have just arrived at your organization, and it's not fair for them to say, in a month, we should have, you know, been able to get everything done, your eye exam and everything else, but that will show up on their action list that they need it done. Does that help a little bit?

COMMISSIONER HIPPLER: Yes.

MR. HIRST: The action list is a detailed list of who needs what and when they need it, and the beautiful thing about that is that you can be proactive about it. If you respond to metrics, you know, you don't want to wait until

somebody is overdue because then your metrics tend to do this. You know, you're just kind of -- okay. They're overdue. We get it done. They're overdue. We get it done. But if you're proactive about it, you can see when people are coming up, and you know, with a month to go, you're making contact to say, hey, listen; did you know you're coming due for your cervical cancer screening or your breast cancer screening? And you do it proactively. You don't wait until you get a reminder that says, oh, did you know you're overdue? We try to get to the thing, hey, let's make sure that you're getting them on the regular intervals that you need to get them done.

CHAIR HURLBURT: And any other questions? Did you have one? Mike, thank you very much for sharing this with us. And Michael, if you could share your perspective?

MR. ACARREGUI: I sure will. So good morning, and thank you. And I see I'm wedged between morning and lunch probably, so I'll try not to take too long.

My name is Mike Acarregui, and I've been up here for almost two years. I came up here as the Children's Hospital Director, then got drafted into the CMO position in the last year, about eight months ago. My background is, as Dr. Hurlburt said, a pediatrician, but I sub-specialize in neonatology. So really, it's newborn intensive care. I spent 20 years as an Academic Neonatologist at the University of Iowa prior to coming here. At the University of Iowa, I ran a

basic science research lab, was involved in clinical research as well, and moved also into quality and safety within the hospital in ICU, service excellence, and in the last several years, also doing clinical work and clinical and research, but ran a statewide public health program in perinatal care. So I have an interest in, really, all those things, probably A.D.D. related.

With regards to data, I'll get into that background. I love data, right? I mean, we all -- we do. We like to collect it, and you know, hold it close sometimes, share it when possible, but I also understand all the problems, and the problems are that it's, first of all, very expensive to convert data into information or actionable information, and it's additionally expensive and sometimes really naive to think that that actionable information will, in fact, result in action. It just doesn't happen as much as we think. We know, at least with regards to medical care analyses of, you know, firm recommendations, evidence-based practice shows that it can take 17 years to adopt something that's just clearly evidence-based in terms of practice. It's slow. It has a lot to do with how physicians think and how they're trained, and it's interesting. And you know, obviously, I think all of us would like to see that gap narrow and that timeframe narrow. So that's just kind of a baseline.

The -- I moved from academics where all the physicians

are, essentially, employed, similar to the SouthCentral Foundation. I love your model; it's great. But I now live in the world of a community health system and a community hospital where virtually all of the physicians are privately employed, and most of them are self-employed. For example, our general surgeons in this town, and really throughout the state, we have one small group of four, and everyone else is independent, and the small group is not viewed favorably in that way. I mean, yeah (affirmative), as individuals, great, but the idea that they have coalesced into a group is not favorably viewed. So we have some real challenges here.

So I thought what I'd do is just kind of a quick summary and kind of overview of the kinds of things that we do with data and then maybe some broader -- some comments on broader issues.

Our data collection essentially starts when the patient is admitted. So we're thinking in a more acute care setting. So from the time they're admitted, we have an Electronic Health Record, as Mike mentioned. It doesn't communicate with theirs. It doesn't communicate with most of our providers' records in their offices. It is, by most accounts, the best thing going out there right now. It's the one that's most used. It's going into big centers, but it doesn't communicate well. So there are some limitations.

Within the hospital, it works reasonably well, and data

can flow from it. We have data that goes to CMS. We have data that goes to Premera, which is our vendor for all kinds of data that we collect and get back in terms of quality and such. Data goes into -- getting closer to the patient -- something that's called Amalga, which is this big program. It's kind of a data warehouse, but it's got really smart stuff inside it, and what it spits out is a variety of things, and in fact, actually works with our modified early warning system in patient care. Sounds pretty cool, right? MUSE is what we call it, is the acronym. And what it does is very cool. It is tracking every patient in the hospital all the time, and it keeps a score, and those scores are based on vital signs, essentially, and when it sees that somebody is having difficulties, it actually alerts a team to the patient's, in Bed 374, respiratory is going up, their heart rate is up, and their blood pressure is down, and you need to go see them now. Their phone ring, and they go. It's very cool, and it's very proactive and real-time.

So that is, I think, an interesting and important use of data and that's something relatively new to us, so we started this just the last couple months. Prior to that, we didn't have the automatic alerting. We had to log in and look, but now it's automatic, and we now track the days in between codes in our hospital, and they're getting further apart. So I think that's a positive thing.

The other kind of data -- we use data all the time. We use it to help with physician care. We certainly track things, like infections, (indiscernible - voice lowered) events. We also subscribe to a surgical database, a national surgical quality improvement program, and that helps us track individual surgeon issues, and we're new to that, but those data are going to be shared soon or that information will soon be shared with individual surgeons, how to move some of that. And it's great because, for the most part, our surgeons say they want those kinds of data. So that's a good thing.

You know, when I think about data and how we use it for cost, we've used it to drive things like having fewer Caesarean sections before 39 weeks or induction before 39 weeks. We benchmark that; we share that with our docs.

In the future -- I'm trying to think in future state. We really need a -- what I would love to see is a better Electronic Health Record, one that will connect with others. You know, the promise for the EHR was that it was going to be the glue that would hold our whole healthcare system together, and right now, it's kind of -- it's contributed to the siloing of different groups, and it's not easy sharing. It's a problem. It will get better, I think. Maybe in 2014 is the magic time, but it's coming.

When I think -- as said, the All-Payer Claims Database, again, data heaven, you know, maybe, but it's going to take an

army, and I think, in many ways, there would be -- there is also a lot of overlap because we have a lot of data out there already, and we have a lot benchmarking available. We have a number of existing programs that help provide data to us. Certainly, claims data, through CMS, is all there. That helps drive quality and kind of pay for performance. And so I think the All-Payer Claims Database would probably be more helpful from a population standpoint, and I could see the value in that. If things -- if we improve transparency, we might be able to get more of a continuum of care kind of look at population health and how we can impact that throughout, not just an acute care setting, but in primary care and even end-of-life care. But right now, I see it would be hard. You have to know. Sometimes, you don't know the true value of a database until you've had it for a while. You have to be smart enough to set it up to get all the data that you might need in the future, and you don't know if it will be useful, but there is a lot of data that sits there untapped, too, and then you have to wonder what the value of it is, and it can be very expensive.

And the other thing, I think one of the barriers to this kind of database is actually that you need a long-term view. So if you find that it's costing, you know, $10 million a year to maintain this and to actually try to implement and all that and then our legislators are looking for where can they cut,

these kind of things can be cut quickly and then you've lost all the previous value. It also can take a couple years to actually have benchmarking data because, you know, it takes a while to have a baseline. So there is kind of a cost to that and that has to be figured in to part of it.

So overall, we use data in a lot of different ways. I'd be happy to expound onto any of that, if you have questions. When we look at, you know, just think about the 30% issue, we can certainly use that to drive, you know, what we're doing and where we can cut down, but at the same time, our payer systems are such that we would prefer to send our bills to Mr. Davis and get paid for every laboratory and imaging study we do. So the incentives are all wrong, and until we have a shared risk model, I think that we're not going to get to the bottom of that in our community-based system. So that's all I have.

CHAIR HURLBURT: Thank you. To what extent has Providence seen community physicians signing up for (indiscernible - voice lowered) as their office-based EHR?

MR. ACARREGUI: Yeah (affirmative). That's a great question. There aren't that many. We have a few clinics and individual providers, but not -- there's not been a migration to it. Some of that, I don't think it's so much cost. I mean, we've got a way to underwrite a lot of the cost, I think a big 75% discount. But there is still, in this community --

and again, I'm new to the community -- just a lot of suspicion. If we -- and even very closely aligned groups, such as Alaska Heart Institute, they went with a different Electronic Record, and they did that -- at least what I was told, and I wasn't involved in those discussions, but that the concern was that, somehow, Providence would then have access to their billing and other records, and they didn't want to risk that. It's not the case, but there is just that level of suspicion on the community, and I guess we're the 800-pound gorilla. I don't know all that history. I try to avoid it, quite frankly.

CHAIR HURLBURT: Thank you. Other questions? Yes, Keith?

COMMISSIONER CAMPBELL: I'm from Seward, and Providence has a clinic there, and it is -- I think it has the same system there, so you can talk that way. Kodiak? Valdez?

MR. ACARREGUI: Yes, and the others do as well. So outpatient clinics in Seward, they do, and they have had it in Kodiak. Kodiak just went live with EPIC in the hospital and that's an advantage, too. So really, we certainly will form a network, but you know, it is kind of sad that they don't all talk to each other, and I suspect it would have taken a lot longer to implement Electronic Records. It would have been harder to find companies that would support that, without the proprietary nature and their ability to really charge more and

more. I mean, they are very expensive.

CHAIR HURLBURT: Other questions? Yes, Dave?

COMMISSIONER MORGAN: That's proven to be a problem for community health centers that are trying, unless they're tribal. The non-tribal community health centers have a problem in order to show that they're community health, medical home, primary care activities to have an effect, because they really can't track the things that are changing in the high cost areas, bed days, ER visits, and pharmacy, after they leave the community health center activities and get into tertiary care, and this is going to be the Achilles heel of this whole deal, I think, in that it's like Yugoslavia. You've got 14 languages going on here, and we're all trying to show, justify, and follow what's going on in order to manage because, if you can't manage this, then you can't do the stuff that's outlaid on this 1,400-page bill I've got here on my screen where I'm looking up information on EHR that's in it and that's the one -- I think that's probably one of the five big dirty secrets in this. This will stop us from getting to where we want to go, if this -- if we're going to make this thing work.

MR. ACARREGUI: I would just -- I think you're absolutely right. I can tell you, locally, we're trying to engage a variety of, you know, health clinics and others as partners, but there is a real reluctance, and until we have that common

language and can pull it together, it's going to be a challenge for all of our patients. I mean, they end up with really segmented kind of records, right? You don't have any longitudinal data, unless you can get to claims data, for example.

CHAIR HURLBURT: Let me -- maybe -- and I'll probably show my ignorance in following through on that question, but pose it to Mike. I remember, when I worked with group health and talking with Ingenix, about building a data warehouse, which the company (indiscernible - voice lowered) decided they wanted to do it themselves and spend a lot more money, didn't get there, but basically, what Ingenix said was they could take the data from multiple sources, multiple programs and pull that all together and turn it into information, even though you had all these various products out there. Why can't that same kind of thing -- and this is where I'm sharing my ignorance. Why cannot that same kind of thing happen, say, between EPIC and Cerner, so that you could have an uber program or a warehouse that can communicate that data? Is that just technically not feasible or not financially attractive or what?

MR. HIRST: Well, in my opinion, it's because -- well, some of it's financial. So some of it, you would have decide -- you could do it through messaging, if you wanted to do that. So you could set your EHRs up to send (indiscernible -

voice lowered) messaging to a central place, if you wanted to do it that way, but then you also have a lot of historical data that's sitting there, that's been there, that has to be included so that, when you're looking at someone who -- you know, if I'm doing breast screening -- they had a mastectomy ten years ago, that information needs to be available, and a lot of times, it's in a warehouse or in an archaic system that we've got. We've got to include that. So that's kind of why I tend to lean towards the warehousing piece and mapping towards a central -- like I said, SNOMED codes are something new. I mean, they're not new, but they're new, really, to the EHR environment. I know Cerner is included in them. I'm not sure; does EPIC have SNOMED codes in them, too?

MR. ACARREGUI: I'm not sure.

MR. HIRST: I know CMS doesn't. So a certified system doesn't necessarily have to have them in it, but when you look at the requirements of how they're doing, you know, that they're pulling this information, you know, who is going to be excluded, who is going to be included, a lot of it's based on those SNOMED codes. So they have the methodologies that they've developed, but the EHRs don't all have that nomenclature built into them yet. So the DOD, the RPMSes of the world are going to have to build that capability in them, but I think that's going to be where you have to go back (indiscernible - voice lowered). 2014 is going to be the

requirement that they do that. I don't think you're going to get immediate standup of everything in 2014. It's probably going to take another couple years for people to be able to do that. So I'm being realistic. When CMS talks about sending data and reporting on it from a user level, you're probably looking 2016, maybe at the best, because 2014 is going to be the requirement that they actually have the pieces that they to have in it, if they don't already have it. So the Cerners of the world have it in it, but they -- and I think the EPICs probably have it built in as well, but.....

MR. ACARREGUI: Could build interfaces.

MR. HIRST: Yeah (affirmative).

MR. ACARREGUI: It is doable. I mean, there are interfaces with all the different programs, and I suspect that there is a Cerner-EPIC interface available or out there. I'm just not sure, you know. And you go, well, what's it going to cost, and you know, why would you do it? Well, for public good. Well, okay. Good. So then, you know, is the State going to help with that? Those are the questions I hear all the time. But then if you get those, so you get the big ones communicating, but every office has their own little, you know, EMR from some other vendor, and it just goes on and on.

MR. HIRST: So one of the things I was thinking about, too, you know, was something you could look at strategically. I mean, again, this is just a thought, but if you had a

centralized warehousing piece where people weren't necessarily sharing the data, you had your own, separate piece in the warehouse, in the cloud, whatever you want to call it, I don't necessarily access your data. You still have patient-level data in that warehouse. I can have mine sitting there, but we can share the same tool, like we were talking about here, that can generate the metrics and produce reports for both of us, but we're not necessarily sharing data. That way, we would be standardizing stuff. We'd be consolidating it, be able to work with it, and I don't have access to yours. You don't have access to ours, but we have the system to make it work, and I think that could be even a reality for some of the smaller places in the outlying villages that say, we'd be willing to put our stuff in a cloud, but not share it with anybody. In other words, nobody else is going to see it. If you could get them to do that in the same tool, you could use the same methodology to run everything for everybody and give them -- the benefit would be they would get reports back, just like everybody else gets. That would be part of the deal, and they would also be able to do their reporting and everything else from that, and quite honestly, after that's done, if they wanted to delete the data out, I don't know what the big deal would be, but I think that's a possibility as well.

CHAIR HURLBURT: Jeff?

MR. DAVIS: I'm reminded of the adage, "Better to remain

silent and be thought a fool than open your mouth and leave no doubt." So here I go, to remove all doubt because I know not of what I speak, but I think, to your question, that that's what the eHealth Exchange is supposed to do, is to be able to take this information from various sources and make it all look common and then be able to spit it out to another place, you know, to us with a limited data set or to another provider who is saying, gee, tell me; has this person ever had that? You know, that's what I understand the function to be.

CHAIR HURLBURT: Any other questions? Val?

COMMISSIONER DAVIDSON: No. I just said it's like the UN translator help.

CHAIR HURLBURT: Right.

MR. HIRST: The continuity of care documents, I think -- so there are subsets of this that are set up, like continuity of care documents where they've kind of structured every system will agree that they'll do continuity of care documents a certain way so that those can be shared, but it's not on a large scale yet. So I think we're moving in that direction. It's just that -- yeah (affirmative) -- it hasn't -- yeah (affirmative) -- just packages of small stuff for certain things, but not from a global perspective.

MR. DAVIS: That's what our guys were all excited about was that one package that's standardized that the Alaska eHealth Network is using that had data that should be

consistent and available, that was useful. So yeah (affirmative). There is some progress being made. I like the UN translator comment.

CHAIR HURLBURT: Thanks again to everybody on all three panels for the fascinating information that you shared and the perspectives and your openness. It's lunchtime, and we'll take a break for lunch until 12:30. We'll have the public comment period, as we usually do. I would ask that -- there will be enough lunch for everybody, but if we can have the members of the Commission go first, just so we can eat and get back to the table by 12:30 to start the public comment period. Deb, did you want to say anything? Okay. So we'll break until 12:30 then.

11:56:27

(Off record)

(On record)

12:31:13

CHAIR HURLBURT: We're going to go ahead and start our public comment period, and we have three folks here, one of whom is Jeannie Monk, who is scheduled on the program, but has some other issues that she wants to share some perspective with. And so Jeannie, we will go last with you and then we can just move right into the rest of the schedule on that. And then for anybody online, we'll have the two folks here that have the comments and then open it up to anybody online,

if you could just let me know now and speak up. Anybody online now that knows that they would like to comment, could you just let us know? Okay. Anybody who is not sure and is still thinking about it, well, we'll come back and open it up again.

The first person that we're going to hear from is Peter McClung. As I mentioned earlier, Peter has sat in on the Health Care Commission meetings in the past and is interested, and from our standpoint, has an interesting perspective coming with his affiliation with the British Columbia Medical Association there, and he and I were just chatting. I think that, often in this country, we'll -- when we look at the problems of our healthcare system, we'll say, oh, we ought to be just like this, that, or the other country, and sometimes, Canada is named, but I think we all realize what we're looking for is an American solution, because our cultures are different and that also it's helpful to sometimes realize that these other countries, where they do some good things, just like we do in this country, that's it not Nirvana, and there are problems everywhere. So anyway, whatever perspectives you have, Peter, I appreciate you being here again, and we look forward to hearing what you say.

MR. MCCLUNG: Thank you. I appreciate being allowed to speak, and I will start by saying that I really enjoy coming to Alaska. It's always treated me very well. So sort of.....

MADAM COURT REPORTER: Sir, I'm sorry. Could you really try to speak into the microphone? There you go. Thank you so much.

MR. MCCLUNG: I apologize. Just to give a bit of background, as Dr. Hurlburt said, I am a Health Economist with a B.C. Medical Association, and so in that capacity, I represent the physicians of B.C. and that's sort of the viewpoint and the framework from which I do my data analysis.

And then to give you a bit more background on B.C.'s system, it is a single-payer system. It's -- for the hospitals and for most services, including nurses, it's global budgets and they're just sort of lump sum payments, but physician services are all paid fee-for-service and that captures roughly 85% of all physician payments, and it captures 85% of the population in any event year. So it's a very large picture of the healthcare in B.C. and that is what I analyze. That is what I look at. That's what my expertise is in.

So hearing these comments about how people use data, how people use claims data, what I've heard from the previous presenters this morning, it's identical to my own experience. It's -- there is nothing different in terms of the hopes and the dreams that people have from the data and the actual, practical, okay, now that we've got the data, how do we turn it into useful information. I don't know how many times I

heard that said this morning, but I would repeat it again. Data is not information, and even standardized reports are not necessarily information as soon as they get taken out of context. And I would stress that, for this group in particular, any dashboard, any standardized report, any Web-based, canned data analytics has to be viewed through the context that it's perceived. It's one where there's -- these are all provided with good intentions. They're all done with the best interest at heart, but it's so easy to move from that into we have this data. Let's turn this into something else, and it's not necessarily going to be correct.

The first thing that always happens with us whenever we release data, without fail -- it doesn't matter what we release, but the moment we release it we are immediately criticized by the physicians, and this is who release the information for. This is who we release the information to, and we say, aha, we've been able to analyze this. This is how we can help you by telling you A, B, C, D, and the first thing they do is they criticize the data, and they criticize it with very good reason, because there are always outliers. There are always exceptions. There are always anecdotal case studies that they can cite that contradict what we've produced.

As a very simple example, we have, in our claims data, I think, it was a 75-year old male that gave birth. I mean,

this is what the system paid. And so this 75-year old male delivered a child and was paid for it, right? It's obviously wrong. Without doubt, it is incorrect. However, it's what the payment data said. And so we take the approach of saying this is what the data said, and when we are giving you data, we are giving you data. We are not giving you information. When we are asked to analyze the data, you need to have the expertise, preferably in-house, because you need to be able to say what are we looking at, and you need to have the expertise that says we know we have problems with our data. We know we have issues. We know we have diagnostic coding errors, and this is how we can correct for these things.

All that said, I do think that claims data/payment data is very, very helpful in terms of it gets submitted, and it gets submitted promptly. I mean, we have a mantra that just says follow the money. If you want to know what happened to a patient, what happened to the patient is, is what was paid. If you're looking at the $2.6 billion that I heard mentioned this morning that the State pays for health services, follow those dollars. Where do those dollars go? Who did they go to? And if you can tie it to the patient, you have a very good picture, in aggregate, of where the money is going and then you can break it down to subsets, and you can say, all right, for patients who are quite likely diabetic based on the diagnostic codes, what happens? And you can look at all that,

and you get a very good picture. When you get down to any particular individual, you'll get criticized. You'll get challenged. You'll get packed. You'll be told, oh yes, but for this particular individual, this is what happened, and invariably, that's true. If you're looking at a big picture, then it's very, very helpful.

And I can't stress enough the difference between information and data. It's one of the -- without exception, the first -- well, I shouldn't say without exception. That's a bit bold, but you look at it once, and you say, okay, we have a picture. We have a rough idea of if you're referral patterns, and you say, all right, a patient shows up in Bethel. They get transferred from Bethel to Anchorage and then from Anchorage to Seattle, back to Bethel. How often does this happen? We can look at it. And you might find that no; that doesn't happen. They get transferred to Bethel and then they go straight to Seattle and then they come back to Bethel. Yes or no. Probably at the moment, people have a lot of anecdotal stories, and they aren't really sure. Is it an issue? It is a problem? Who knows, right? But you get these answers by looking at the data.

The other caveat that I would add to is, once it's answered -- once you have the answer to one question, it always leads to more questions, and I think that experience is universal, whether you're looking at clinical data, whether

you're looking at health records, and you're saying, okay, we want to track a subset of our patient. We want to track the performance of a particular office. We want to track a particular hospital. Whatever it is, once you learn a little bit, then you want to know more and you want to know more and you want to know more. And as one of the earlier presenters said, that's nice. That's great. Where is it actionable? Where does the answer to the question actually result in the ability to change what you are doing? And it's very interesting. It's very exciting, you know. It's one of these things where you get these very nice charts. You get these beautiful graphs, but at the end of the day, if there is nothing involved that you can change, that you can affect, that you can, in some way, impact, it's an awful lot of effort for a very nice graph that still doesn't change any of the behavior or the patterns or the trends.

And then the last thing I would stress on that is standardized reports, which I imagine as sort of the bread and butter for most organizations and most vendors, they're excellent. They're necessary. They really, truly help you see, over time, what's going on, what's happening with your patient population, what's happening with a specific patient, but they always lead to more questions. They always lead to people wanting to drill down and get the details and that's where I think the in-house expertise -- if you don't have the

investment up front to say we're going to train people that really understand our system, our data, our situation, you're going to run into a lot of problems where the moment you ask an external party, could you please look at our out of state retiree -- and they'll look at them, and they'll give you a response, and they'll give you an answer, but it probably will immediately be criticized because the way they've looked at it, the way they've analyzed it didn't take into account all these important factors that were so obvious to the person asking the question, but were unknown to the person doing the analysis. And I think that's based my own experience in Canada with a single-payer, but from what I've heard, the experiences of the providers and patient flows are very similar.

CHAIR HURLBURT: As a data kind of person working with physicians, for physicians there, there was the comment made earlier, which, in a lot of ways, was quite correct in the sense that providers seem to be relatively slow to react to data and evidence and then a 17-year number was cited, which probably goes back to the experience that that's about how long it took to get beta blockers adopted in this country as being routinely used for a post-MI patient with improved outcomes.

But my own experience has been that, when you provide -- physicians are trained as scientists, and when you provide

data to them, which -- particularly when it shows them to be an outlier, that, almost always, the initial response is a push back, and you don't understand; my patients are different. My patients are sicker or whatever. But usually, the second or the third thought then is, well, why? And then they really do look at it, and physicians really do, in my experience, react to data constructively.

Now where you're on the physician side of the negotiating table in the kind of system you have in Canada, what is your experience there, working with physicians collectively in that area?

MR. MCCLUNG: Physicians are definitely very data-driven, and I would fully agree with that assessment. And once they -- their first reaction is my patients are different. And if you can then say no, your patients aren't different, or you know, explain to me why your patients are different and we can go from there, and once they agree, no, my patients aren't different or my patients are different, but it only counts for 10% of my variation, you get huge improvements.

And on behalf of physicians, I truly believe that physicians, 95% of them, they get into medicine because they want to help people. They aren't getting into medicine because they want to gain the system, because they want to, you know, play around and make as much money as they possibly can. They want to help patients, and they want to help

people, and they want to do the right thing. And yes, it's good that society rewards them for doing this, but they're also trained to be the expert, right? So they are trained to know this. They are trained to do the right thing. And if someone, like myself, shows up and says, I think you could be doing something better or you could be doing the wrong thing, it really is an attack on their identity. And so in terms of negotiations, I really have to work hard with them before I even approach the government, and I use chronic disease management as an example, where, with diabetic patients, doctors -- uniformly, they treat their diabetes patients exceptionally well, was the statement that they would give to us. They didn't need any other incentives. They didn't need any registries. They didn't need any of this stuff, but if we could get money for it, if we could get funding for it, then go ahead, like all right, you know. If they're going to get paid more for it, great.

And so we were able to secure funding for management of chronic disease patients, and the first thing that happened was it prompted doctors to look at their own patient profiles to see how many patients they could claim as bonus payment for, and the number that I was told -- the average number from physicians was that, of their entire diabetic population, roughly 15% were being treated very well, and these were the patients that they knew were diabetic that were being treated

very well. And then they had another 60% that were being treated moderately well, but they weren't that compliant, and really, how much could the doctor push. And then there was another 15% they knew nothing about. They were on the Diabetes Registry. They hadn't seen the patient for two years. They had completely forgotten that this patient was part of their profile and would consider them their family doctor, and it prompted them to say, well, look, you know, these are patients that I'm missing. It's not intentional. It's completely accidental, but these are patients who are being completely missed, and those are the patients that are the high flyers. These are the very expensive -- they're visiting the emergency department. They're seeing the endocrinologist. They are being admitted. They're not connecting with any primary care providers. They're costing the system a fortune, but by having the physicians look for them themselves, sort of proactively say, well, we're going to find these patients and manage them because now we're being paid to do so, we're being paid this bonus, which wasn't their incentive to start with -- they're sort of like, yeah (affirmative), sure, give us the bonus, but it's what caused them. It's what triggered them to actually review their own data. It's made huge savings. So it's -- it can be very, very effective if done properly.

Another example that I throw out, which was a very

immediate quick financial win that we saw, literally, overnight is we were able to look for the claims and we could identify diagnostic tests that were being ordered, and there was a very high number -- I think it was -- I believe it was B-12. It was either B-12 or folic acid that was being routinely tested on patients, and in Canada, which I think is the same in the U.S., it's added to the food. It's in bread and cereals, and there's really no need to test for it, unless you suspect that there are other dietary problems. But some physicians that had been practicing for decades routinely bill this -- or routinely requested this test and so they were written a letter. I think it was the top 100 were sent a letter that said you're significantly beyond guidelines. Your patient population -- almost all of your patients are being -- are getting tested for this; could you please explain to us why? Here are the clinical guidelines; could you please explain why your patients are being tested? Ninety-five percent wrote back and said thanks for letting us know -- or actually, 95% didn't write back, but 95% that were contacted said thanks for letting us know; we'll stop doing it. And they immediately stopped. It was literally within the span of a week they stopped ordering that test. They had no financial benefit. They had no financial penalty. It was just it's the right thing to do, and it was very easy to show, and we could see it. We saw the data. Within a month, we saw the drop in

tests. I mean, it was replaced by the next 100, but it's an example of how you can look at the data, you can see things that really don't make any clinical sense, and you can request a change or you can suggest a change, and if it's done with some degree of sensitivity, it's well-received.

CHAIR HURLBURT: Thank you. Any other questions for Peter? Keith?

COMMISSIONER CAMPBELL: Does it matter psychologically to the physicians that it's their person you presume will be writing these letters versus some other government entity or something?

MR. MCCLUNG: I think it did. I think it made a difference that it was a joint effort by the Medical Association and the Ministry of Health in a -- it was -- literally, it was a question. It was an investigative question that said we're trying to look at the way care is delivered, and we have noticed that your patients are receiving a lot more of these particular tests. Can you please explain to us why? And there were less than a dozen physicians that had very good clinical reasons. They had niche practices that it made sense that they were ordering these tests, but the vast majority of them, it was just standard practice, and they just hadn't adapted their practice. And the way the letter was phrased, we ran it past focus groups first, and it was one of, as a physician, do you

understand that we're not trying to find a way to penalize you, or you know, drag you before some Medical Oversight Board. We're just trying to find ways that we can improve the system. We know that there is waste in the system. We know that there are things being done badly. How does this come across? Once we got the letter well-written, it was generally well-received.

COMMISSIONER STINSON: To kind of address what Keith said and also what you've been saying, for the State Medicaid Program, my practice partner, Dr. Roderer, and I are both Pain Specialists, and on people who have been requesting overrides of the Medicaid guidelines for opiate medications, they have been forwarding those to us, and what we do is we cite literature and go through the patient's record, and not in a negative way or confrontational way, but cite what they're on, how they got there, and then cite specific literature about maybe that's why that's not the best way to go and then make recommendations on how to moderate that, and then they're given the opportunity to either contest what our opinion is or talk to us in a phone conversation or otherwise appeal again to Medicaid. And so far, there has been zero additional appeals where, prior to this, my understanding was that was a regular daily occurrence.

So I think, depending on how you approach it and if you approach it in a way that the physicians can understand it,

particularly if there is literature to support it, most people are fine with that. I think, if you're just saying, oh, you've got to do this because you've got to do this, most of the physicians in Alaska that I know of would probably have a problem with that, but if you do it in an educational, or as you said, scientific way about how we can help your patient, it goes over very well.

COMMISSIONER URATA: I have two questions. One is, what is your Electronic Medical Records system like? Is it one system for everybody or is it a mixture, like ours? And how do you make it work?

And then number two, I find it interesting that you are being hired by the B.C. Medical Association, and I'm wondering how that came about. I can't imagine the Alaska Medical Society hiring a person to do what you do, and you know, I guess I should be like others, and you know, are you planted there by the government?

MR. MCCLUNG: To answer your second question first, when I first -- I showed up at a Surgical Quality Conference, and this was when I first joined the B.C.M.A., which was ten years ago now, and a few people -- and these were all physicians that were in this conference, and a few of them looked at me, and they said, what are you doing here? This isn't about money, you know, and they really thought that I was there against them, and it's one of -- I believe the B.C.M.A. has

successfully upset every specialty group within B.C. during its existence, and I sometimes joke that, well, actually, we only care about really rich people, you know. We don't like children. We don't like cancer patients. We don't like any of these people, because every specialty group says that, somehow, we've worked against them to thwart them.

But overall, in general, the B.C.M.A. has its Economics Department largely because, for negotiation purposes, we want to be able to demonstrate that, because we're only dealing with the single-payer, right -- I mean, this is where all the money is. And so we negotiate for our fees. We negotiate for the total compensation, and the government -- we've always had an Economics Department, and it's largely that we've been able to say this is what would be fair and appropriate compensation for a physician, and in order to assess that, we need to know what people are compensated. But it's also because the government is so concerned about the escalating cost of care that we need to be able to say we're a good investment. If you invest in physicians, you're going to get a good bang for your buck. And sometimes, that's a challenge, right? I mean, part of it is that, like any good lawyer, we want to know the answer to every question we ask. And so anything that we pursue, we want to be able to know the answer.

We have not pushed for a fee for an average annual physical because the data isn't there. It doesn't support it.

And so we would lose our credibility as being true advocates for patients if we showed up in government negotiation setting and said, look, we need money for an annual physical, because they would just turn around, and they would say, but the evidence says that this is not good value for a whole host of patient populations and that's where we're employed.

Second to that, the government has no interest in just paying more for the same behavior. They don't want to just raise fees. They don't want to just throw good money after bad, as the saying goes. And that's where people, like myself, are employed to say, how can we truly improve patient outcomes? How can we truly show that a dollar today will save you ten dollars ten years from now, which is a bit more difficult. It's a lot trickier. There is definitely uncertainty involved, but that's why we're there, and the physicians certainly see the benefit, I think.

I mean, speaking to that point, I think that, due to expertise that we have in the B.C.M.A. and sort of our sole focus, we are able to come up with much better examples and arguments than the government is because the government has so many other competing interests and demands on their own resources. May I address your first question as well?

DR. URATA: Oh, sure. And I have a follow-up, actually, on this. So can I just have a follow-up on this?

So what's your recommendation for an excellent database

to do your job? Would what we were talking about this morning, the All-Payer Claims Database be part of that or an important part of that?

MR. MCCLUNG: I definitely think that you need to have a good, robust, longitudinal, over time, consistent database. The All-Payers Claims Database, as I'm learning more about the system, I question the value of it for the State. I question the value of it for Alaska in general because, if patients remain under the same payer throughout the system, all you need to have is access to that payer's database. And as other representatives have said, you know, what's the value to us as a payer to share our information with everyone else?

Now if you have patients that are slipping in and out of various insurance plans, then yes; you would want to know what's happening to these patients. It would be -- just from a research perspective, it would be incredibly interesting to know if treatment patterns changed depending on your insurance coverage. So in that sense, I think it would be very interesting, but it would also be very interesting -- well, actually, to go back to the question of what do I think the value of the database is, I think it has to be consistent over time and has it to be looked at and owned by somebody that is able to understand it and is able to access the clinicians who are able to explain it because you will have all sorts of things. People get paid for particular claims. That doesn't

tell you what the patient's medical record is. It doesn't tell you what the patient's health status is. You need to link it to other systems to do that, which we don't bother doing. We just sort of look at what's the patient paid. We just follow the money, and we're not looking for very specific, precise interventions. We're looking for general, big picture, impact 80% of the population or 80% of the cost scenarios. We're not looking -- we're not trying to chase the last 10%. We're not worried about it. But I would definitely say that the big things are consistency over time and the ability to look into it and analyze it with the knowledge and the expertise that's able to explain it.

One of the limitations of our database is that it has a single diagnostic code, and yet, patients have co-morbidities. And so due to that limitation, you need to understand that, when you're looking at any particular claim, the diagnostic code that's associated with it may not necessarily be the number one issue for that patient. That's just the claim -- that's the diagnostic code associated with that particular encounter, and this is particularly important for emergency visits. People show up in the emergency department because they have a broken leg. It doesn't say because they have osteoporosis; it's because they have a broken leg. So you need to know that. You need to be able to get people to understand that. And then -- yeah (affirmative). May I

answer the question on EMRs?

So to answer that one, I believe your question was, what is the Electronic Health Record in Canada, and how does it work? And the answer is it doesn't. We don't have one. We have numerous options, just as many as there are in the U.S., mostly the same vendors. In B.C., we've spent tens of millions of dollars trying to get all the physicians on to an EMR of some sort. We had a vendor process, narrowed it down to five approved vendors.

One of the key requirements was that these EMRs talk to one another, and every vendor swore up and down that, of course, these things talk to each other. That's the backbone. That's the benchmark. And I believe that the most recent quote that I heard was that, "My EMR talks to everybody else's; they just aren't listening." And it was just one of these -- ultimately, they've sort of done away with that. They've stepped back from it. And so everybody who is -- we don't have EPIC as a vendor, so I'll pick on them because they weren't on the approved vendor lists, unless they're under a different name. But everybody who was on EPIC could talk to everybody who was on EPIC, but you couldn't talk to anybody who wasn't, and this led to all sorts of problems. They were very much -- because it was for physicians, the vast majority -- we have 10,000 physicians in B.C.; approximately 5,000 are family practitioners, and the other 5,000 are specialists. So

basically, it was a family practice EMR. This had nearly no benefit for specialties which are very image-intensive, such as ophthalmology and radiology, and so they just didn't use it. They just -- they had no interest in any of the vendors, and they had their own very effective programs that worked very well for them. They were already organized into relatively large groups. So they didn't have either the financial incentive or the clinical incentive to join any of these approved vendors. They still can't talk to each other. My understanding is, currently today, people are now trying to look at the benefits without the communication piece, whereas eight years ago when we were working on the funding for all of this, it was the communication piece that was going to be the (indiscernible - voice lowered) that would save the day.

CHAIR HURLBURT: One more question. Dave?

COMMISSIONER MORGAN: I like the concept of following the money, but it sounds like you sort of do, through your process of managing this or finding out what you need to correct, is you're looking at the 20% or 30% of a diagnostic category or a problem that's utilizing 80% of the high flyer part. When you do that and you pull it, then you look at the money, who you've paid, and the patients; you list the patients or medical record number or something so you know who it is. Is that -- when you actually get to the action part of this, do you use case managers? Do you have a social worker that sits

down with the patient and the vendor? How do you -- I think, sometimes, we get wrapped into, what is the system and what are you reporting? So let's take the next one, which is let's pretend that, whatever that is, you've got what you need. How do you turn that in to reducing bed days and waste? What's that next step that you guys do, or hopefully, you are having an effect, right? Okay. Good.

MR. MCCLUNG: I have to laugh at, are we having an effect? It's -- we are also a very siloed system. And so to use the example that you give where it's, like, so behavioral health issues. You know, you track these patients. Yeah (affirmative); they have mental health problems. This is a significant issue. They need ongoing, regular support of some sort, and we do run into the political hurdles, the siloed walls, the fixed budgets of different departments. And so to some extent, we do get limited. We come back, and we say this is what we've looked at. This is our recommendation, and we can even take it through to the point where this is the recommendation of the Ministry of Health Medical Services Branch, which is the physician payment branch, that the Medical Services recommends that the Health Authorities Branch invest more money into these resources and purposefully goes out and targets these specific patients. And sometimes they agree, and sometimes they don't. Sometimes, it's one where they say thank you, but that's not our priority area. Our

area is somewhere else. And so it's not one of -- we can't implement every recommendation, but we do have a lot of confidence in what we're suggesting and that does get trashed, and it takes a lot of time. In terms of reducing bed days, it becomes very tricky because there are so many other issues at play, and the system is always in a state of flux. There are always things that are happening. And so if it takes four years to actually implement a recommendation due to everything else that has changed at the same time during those four years, to what extent was the recommendation the cause or the -- to what extent did the recommendation make the effect becomes murky.

COMMISSIONER MORGAN: Well, no. What I was trying to get at was not necessarily just bed days, but you find the problem. You track the money. You get your group of patients, your targeted group or your targeted diagnosis or whatever it is, and it sounds like then you do a series of recommendation either on the payment side or the reimbursement side, but then you may say this group of behavioral health patients needs a social worker to do case management or something. Is that, basically, what you do and then follow it and look at what the input costs were to make the change and then track whether you had an effect of bringing down the payments because you corrected or stabilized the patient, so they're not using as much of whatever you think they're using

to much of? Is that a better way of putting it, I guess? I'm trying to figure out how you do the third step.

MR. MCCLUNG: Right. Right. So I guess, to answer your question as directly as possible, we don't get that far with the third step. We make the recommendation. We make the suggestion. And certainly from the B.C.M.A.'s perspective, if the government goes on with it, great. If the government doesn't, c'est la vie. And I can say, from just my experience with the government, that, often, even for the recommendations that do get implemented, the prospective baseline setting up the evaluation metrics are not put in place at the beginning, and then retrospectively, they aren't done either. And this is largely due to a resource constraint. It's largely one of, it sounds good, it looks good, it makes sense, we're going to go for it versus what you would hope to see of we're going to try this. We certainly have thousands of pilot projects where things are tried and they are measured to varying degrees of accuracy, but even then -- even if you have a very successful pilot project, to expand it and roll it out within a health authority who has complete jurisdiction, it becomes very difficult. It's very slow going. And largely -- this sort of goes back to the bit about writing a letter to the physicians. It's largely because, in every case, you're dealing with people who think they're doing the best thing, and you're now going to tell them, we want you to do something different. It

becomes a changed management issue as opposed to a simple flick of the switch. So to be completely honest, we don't do that third step very well.

CHAIR HURLBURT: Thank you, Peter, very much. I think we need to move on because we do have three other folks to talk, but thank you very much for joining us and sharing with us. And I think, if there are some other questions, if Peter is still here at the break, he would be gracious enough to talk with you. Nancy Merriman, with your still pretty new hat representing the Alaska Primary Care Association, we welcome you, and we'd like to hear what you have.

MS. MERRIMAN: Thank you, Dr. Hurlburt and members of the Commission. I'm very happy to be able to have this chance to formally introduce myself to the Commission.

I'm the new Executive Director at the Alaska Primary Care Association, but I'm not new to Alaska. I've been here for 20 years already, having worked in Kodiak and at the Municipality of Anchorage and the Denali Commission. So I'm not new to the challenges that Alaska faces, and especially, our healthcare system.

I think that we face an exciting opportunity, and the Alaska Primary Care Association's work and mission is to promote all forms of access to healthcare for all Alaskans. So I'm very happy that a great many of you represent the finest in your respective fields, and I'm honored to be here

before you to share just a couple minutes of introduction.

This is an exciting time in healthcare for Alaska as the focus of the state and federal attention is on access, better service and outcomes and population health and controlling the economics of healthcare.

We appreciate and support the work of the Health Care Commission, and we look forward to more as the good work of the Commission gets translated into state action and state policy.

The A.P.C.A. and I am here to help. We're assembling a good team of folks at the office and aligning priorities with state and population needs and looking forward to working with all of you.

I've already directed some key staff to focus our efforts, engaging more and producing more results, measurable results, and recognize that all players in the health sector are under pressure to produce results.

Nationally, our community health centers have actually improved health outcomes and lowered the costs of treating patients with chronic illness and have compiled a remarkable record of achievement in providing care of superior quality with exceptional cost-effectiveness and efficiency. Their costs of care rank among the lowest, and they reduce the need for more expensive emergency room, hospital inpatient, and specialty care.

Both the Institute of Medicine and the General Accountability Office have recognized community health centers as effective models for reducing health disparities and for managing the care of people with chronic conditions, and the White House of Management and Budge has repeatedly ranked them as one of the ten most effective government programs.

So we recognize that the important role of the A.P.C.A. is to support and defend organizations and agencies working on shared themes, and our relationship with the State of Alaska and state agencies is very special and important to us.

Access to health care is key to all future successes, and A.P.C.A. supports the Health Care Commission's aspirations for Alaska being a very healthy state in our union, and we must also strive for full access.

Barriers to access take many forms. They can be structural, economic, regulatory, or simply based on habit and prejudice, and we must strive to be vigilant about keeping our eyes open to surmount the many types of barriers.

Access, sometimes, just means building awareness of opportunities and opportunities of the individual responsibility, and A.P.C.A. supports state efforts to inform and educate the public about opportunities and responsibilities.

The Affordable Care Act and the Patient-Centered Medical Home model and data management offer many opportunities, and

the A.P.C.A. is engaging our membership accordingly. From my experience, the healthcare workforce in Alaska is one of the most dynamic, innovative, and flexible, and up to the challenges of the future, including seeing more people and getting more good work done for the people and the health of Alaska.

The Alaska Primary Care Association is a membership organization representing all 25 federally-designated community health centers across the state and more than 150 access points. So we're a great treasure of the state, and we're standing ready to help you all in achieving the same mission that I know you are all committed to.

CHAIR HURLBURT: Thank you. Any questions for Nancy? We have had a great primary care focus in all of our discussions through this, so we really do collaborate with you on that. Any comments or questions? Thank you.

COMMISSIONER ERICKSON: Thanks, Nancy, for coming. I just wanted to mention that you might not know that, in the past, we had invited your predecessor to participate with the State Medicaid Agency in updating the Commission on any work that's going on related to patient-centered medical home. So we might invite you back to do that. I would expect -- not we might not -- we will invite you back in that capacity to help with that, and I might follow-up with you afterwards, too.

One of the things I've wanted to do with the Primary Care

Association, we keep kind of an update on the status of implementation of the Affordable Care Act, and there is a section where I've tried to keep updated the receipt of grants for new access points for -- through community health centers, and expansion funds have been coming in. I know there is another whole new round of grants coming up again, but I'll follow-up with you at some point in the not-too-distant future, just to make sure that all the information we're providing for the Commission about that is detailed enough and up-to-date and accurate. Thank you.

MS. MERRIMAN: I'll look forward to a future opportunity to be back.

CHAIR HURLBURT: Thanks, Deb. Dave Hanson, if you'll come forward? And then, Jeannie, you'll be next.

MR. HANSON: Thank you, Mr. Chairman and Commission members. I appreciate the opportunity to testify today. Do I need to give address or anything like that? Don't need any of that. Okay.

MADAM COURT REPORTER: It'd be nice for you to state your name again, please.

MR. HANSON: Dave Hanson.

MADAM COURT REPORTER: Thank you.

MR. HANSON: I'm a mediator and facilitator in commercial mediation and public policy mediation. I'm here not compensated. I'm here as a private consumer of medical

services representing myself, and I'd like to say, right away after hearing the gentleman from British Columbia, the complexity of what you're dealing with, that, not only do I appreciate what I understand, I also appreciate what I don't understand that you're dealing, and I also feel like, today, I'm here for a very simple reason. I would just like to get the healthcare providers telling me, as a patient, what the service is going to cost before they give it to me. That's it. That easy, supposedly.

Now in seriousness, I'm very concerned about the cost of medical care, and the cost of the current system is not sustainable. It can't keep working. We know that, so we need to do something. Unless we do something now to manage the cost of the medical care system, we'll be forced into very, very heavy government regulation, and possibly, socialized medicine. And it'll be because we'll be desperate for a way to control the costs that are going up so fast.

Now, we just had a wonderful person from British Columbia who is in a little more of a government system, and I found it very interesting at how hard it was to change things and implement his recommendations, when they are so well based. That's why I, personally, believe your second core strategy for healthcare transformation recommendation to increase price and quality transparency is part of the solution to contain costs, and I am here today to urge you in those efforts. And

I, frankly, believe that the competitive, open, transparent market system does still have a big role in our medical care, and if we were told what it costs, even with insurance, a lot of us would be making choices to go for the less expensive provider because we don't know who it is now. So I feel it can help competition, what you're working on, and help the system survive.

Shopping for healthcare seems to make sense. When we buy a TV or a car, we shop. We know the price. We know the quality before we make the decision. With healthcare, we don't know the price until two to four weeks afterwards when we receive the bill, and most of us don't know what the product is that we bought, even after the service has supposedly been given.

Now, we have a very intelligent population. We are -- I'm from a doctor family. We also have very intelligent doctors in this state and healthcare people. There seems to be no reason this can't be changed and that it's in the system that has a very good thing going for it now, the medical healthcare system. It's in their interest to change this, and I fully believe that a competitive healthcare system can survive and thrive, that you don't need price secrecy to survive in Alaska.

So with a TV or a car, there is very limited government involvement. There was more in the '50s to set up the

criteria for cars, for example. The competition keeps it reasonable. If we knew the price ahead of time and could compare it, in many instances, the price competition would help hold medical prices down and contribute to a patient's mental health. This is especially true for certain procedures that aren't just in one place, even in Alaska.

Let's talk about MRIs. I'd like to share a personal experience with you, and I have a chart to hand around. I just want to hand it around the table.

A family member had a very painful elbow concern, went to the doctor. The doctor sent her down the hall to have an MRI. The family member was not told the cost or even the range of costs before she had the procedure or that, for this elective procedure, whether she had it that day or three days hence -- made no difference, that she could go elsewhere and have the MRI. We learned the $2,543 cost three weeks later when the bill arrived, and we were angry. The price was $681 above what Alaska Care deemed a reasonable and customary rate. So we had to pay $681, plus 20% of the $1,862 that was considered a reasonable rate. So for a total, it cost us $1,053. I was angry enough to take off a day to go research MRI prices within three miles of this doctor provider. Very available, especially for elective care. Please see the handout for the results.

I put actual names of the providers down because I think

it's ridiculous, when they'll tell me what the price is, that everybody can't know, and if they're embarrassed about their price, well then, they should be embarrassed about their price, and people should know this. In fact, when we tried to talk to the provider about the price, the managers didn't want to talk to us until I threatened to go to the *Daily News* and have an article. This is a problem. It's ridiculous. The cost of the procedure, for the same procedure was all below the reasonable and customary rate for all four providers I went to, except for the provider who gave the service.

In conclusion, if we had shopped first and had reasonable price information access, we would have saved over $700 using the least expensive provider for the exact same MRI procedure. No differences. Same number in the computer. I even checked on the machines. They've got the same machines. So obviously, medical procedure price transparency can help hold down medical costs.

Now, having made that point -- and I have no trouble you publicizing anything on that sheet. I'll stand behind it, and I've got -- I had them write down the price on their letterhead, each place I went. But what I'd like to say is we have many tools now that other states are using to help with transparency. Your own consultant, in Appendix G of your big report -- it's the All-Payer Claims study -- this is what different states are doing, and you're going to be looking at

that shortly. I'd like to pass out something I Xeroxed from that report, and excuse me for being nervous today. I'm not used to being around so many medical people. But anyway, are you trying to say something, Dr. Morgan?

COMMISSIONER MORGAN: I am not a doctor. I'm an economist, by the way. And I feel your pain. Community health centers -- I'll give a plug for our ED -- post -- all community health centers on their sites, all 448 of the sites and 23 programs, you can go in and see what their prices are. It's in a book or on the wall. And I feel your pain. I agree. It's a problem, and we -- if you look at the previous studies, we did a Milliman study that detailed a lot of this. So the reason a lot of us are looking at you and smiling is because you're not atypical. We had a speaker who wrote a book on doing -- he did exactly what you did, except he and noted for his company, but he ran right into the same stuff. So don't be nervous, and I think we only have, what, three doctors here. So that's okay.

MR. HANSON: Well, thank you, and knowing your time, I will finish up here sort of quickly. But knowing you're going to look at these, I did want to highlight some very simple things that can be done, even if they have to be done legally; whereas, I think there is a big moral suasion argument that can be used in a place, like Alaska, on this. But the legal ones. South Dakota lists median prices for the top 25

inpatient and outpatient procedures. All the doctors and hospitals do it. Michigan lists prices for, at least, 50 medical tests, procedures, or operations. Minnesota, they list the amount health insurance plans pay -- in other words, the price they've negotiated -- to 110 different providers for 103 common medical procedures. That would be helpful, especially when you're dealing with a lot of independent providers on some of these things, like MRIs. Nebraska requires hospitals and surgical centers to provide a written estimate of average cost for the specific service. Can you imagine that? When we have a remodel of our home, when we build a house, when we do all kinds of things, we get this, but when we have multi-thousand dollar medical bills, this is almost unheard of.

So I wanted to emphasize those things and bring them up to you, and I think this Commission has a real opportunity. I urge you to try to stay out of the politics. Nobody else is doing this kind of stuff in Alaska where they work with the government to do something like cost transparency. There are plenty of others on many of the political medical issues. So I just urge you to use the uniqueness you have. I'd like to also urge you, quickly -- there is a -- did any of you get a chance to read the *TIME* magazine? A couple of you.

Now, you may disagree with certain parts of it. You may disagree with some of the recommendations, but I have been

doing a lot of reading since I went through this experience a year ago on this, and one thing this *TIME* magazine -- which is just from last week -- does is it gives a very good overview feel of the difficulties we're facing in our healthcare system. So I'd recommend it to all of you from that perspective, that it would be very good for you to read it.

Also, it's so timely -- I'm going to hand it out, but in yesterday's *U.S.A. Today* from the editorial page, they dealt with transparency and pricing in medical care. Now, what's my point of bringing this up? It's simply the time is right. The people are ready. There is great resistance in parts of the medical services community, but it's done quietly. It's very hard for a patient to stand up to the doctor and ask what it will cost when you are, by attitude and intimidation, discouraged from doing it. But I can't say enough, especially in a place like Alaska, how much I think this would help our healthcare pricing, if we knew the prices ahead of time, even with insurance because insurance, more and more, is going to cover less and less, and it's going to become more and more important to the consumer. And based on how hard it is to get a government to move or change a system, I think it's very important for us to try to keep the system we have and make it work through making the customer a big part of the system.

So be bold. Thank you. And in the healthcare industry, I guess, do no harm used to be part of some of the oaths.

Well, secret pricing or not letting you know the price does a lot of harm. Thank you.

CHAIR HURLBURT: Thank you very much for all the work you did and for thinking about the presentation. And you're taking this up. The pressure that business people feel as employers and the challenges they have in wanting to do the right thing by their employees drives this need for transparency.

I want to say one thing, maybe a little on the defense of the physician, that the honest is it depends. And if you access the Milliman study that Dave referred to on our website, if you're going to have this MRI, what does it cost? The answer is it depends. Who is paying for it? Is it private insurance? Is it TRICARE? Is it the Veterans Administration? Is it Medicare? Is it Medicaid? Is it Workman's Comp? And the variation is humongous among payers, just in Alaska, much less the difference between here and elsewhere. So the physician has a dilemma in that, maybe if it's a relatively common MRI, the physician could say, well, this is what I charge, but he can't keep six or seven different payers for all the different things in mind there. That does not negate the need for the transparency and that has been one of the driving goals for this Health Care Commission, to have greater transparency for the individual patient and for the third-party payer to facilitate more

productive negotiating in the marketplace, as you say, that we have a market-based economy in our country, and we want to continue that, but what we have is not sustainable. So thank you, thank you, thank you for bringing those words to us, Dave.

Is there anybody online, quickly now? Thank you, Jeannie. And if you run a little bit over and we shorten the break, that will be okay because -- thank you. Jeannie Monk is with the State Hospital and Nursing Home Association. I assumed everybody knew you, so sorry.

MS. MONK: Great. Well, I have spoken before. Well, Deb asked me to come and talk about the Hospital Discharge Data System, but before I do that, I had wanted to do some public comments on the All-Payer Claims Database from the Hospital Association's point of view.

So I do represent ASHNHA, the Alaska State Hospital and Nursing Home Association, and I want to start off by saying I appreciate the previous speaker's comments. I think many of us have personal experiences similar to that, where we're just bewildered by the costs and the experience.

Alaska hospitals support price and quality transparency for the entire healthcare community, for hospitals, physicians, surgery centers. In November 2012, our board voted in support of a price and quality transparency as one of priority areas, and hospitals recognize that transparency is

critical in the changing healthcare environment. Now what that means and how we get there is the hard question, and I will talk about how the Discharge Data System relates to that in just a few minutes.

So ASHNHA is not opposed to an All-Payer Claims Database, but we're not yet ready to support it. We have a lot of questions. We have some concerns about the process and the timeline, and we really feel like we need to learn more. We need to share information with our members. The report just was posted on the website a couple days ago and so I know I've barely had time to read it, and we certainly haven't had time to send it out to our members and to communicate and understand all the details of the recommendations and to go to the websites and look at the different examples and really digest it.

So we really believe that a stakeholder review process is necessary prior to the Commission making any formal recommendations. I think the point has been made that this is really a longitudinal process and is a really major investment for the State, if we're going to do this. And to rush in to make a decision or a recommendation tomorrow seems premature without all the information.

And Pat Branco, who is one of the Commissioners, could not be here today, and I know he's trying to tie in on the phone when he can. He's at another meeting down south and so

he was really sorry he can't be here and can't have a full voice at the table. So it was one of the reasons he asked me to testify.

So I guess, from the ASHNHA point of view, we would request that the timeline be slowed down, that you not make a recommendation or move forward tomorrow, but think about a process that really gets stakeholder involvement so that we can make sure we have something that will be sustainable over time and will give us what we need.

In addition, you know, we really want to remind people that quality outcomes are just as important to consumers than cost, and so although people may want to look at cost, when your mother -- you know, if my mother needs a hip replacement surgery and I hear one doctor might be 25% cheaper, I'm not necessarily going to go to that doctor, unless I feel confident that the quality is the same. So I think the quality and cost, we need to look at both of them together. And hospitals are very involved in quality initiatives right now and are really looking at -- they're increasing transparency with quality, Hospital Compare, and various other things. In fact, the past two days, we've had a Quality Summit here in Anchorage, where we had 60 people from hospitals around the state meeting to talk about (indiscernible - voice lowered) events, hospital readmissions, and how they can improve their quality. So hospitals are

really focused on this.

The other thing hospitals -- we heard from a couple speakers this morning -- focused on is Electronic Health Record development and connection to an HIE. So I guess my point is there are so many things going on right now that impact data that it's kind of confusing, which is why I want to talk about -- I want to separate my comments about the All-Payer Claims Database from the Hospital Discharge Data System, so to not cause any confusion because there is a lot to consider.

So I guess, for All-Payer Claims, ASHNHA would really ask that a stakeholder group be developed now and that that group have involvement in decision making on moving forward with an All-Payer Claims Database. We really think it's important to build collaborative relationships, so that everyone understands the process and that we take time, prior to a legislative effort, to make sure we know what we're doing and that this be a diverse stakeholder committee or group -- I don't know -- as opposed to the Health Care Commission taking on the stakeholder responsibilities, that people agree to the principles up front, agree to how data use agreements will be set, and look at the costs both for hospitals, institutions, payers throughout the system, and to turn the data -- as we've heard so many times today -- from data into information. So what will that really cost in order to do that? So that's

comments on All-Payers Claims.

Now I'll pull out my other pages of notes to talk about Discharge Data System. So you had, in your packet, a couple different handouts. One is an Alaska Hospital Discharge Data System Summary I've put together for this meeting, and the other is a policy brief that was put together in September 2011 that ASHNHA worked with Deb to put together at that point and I came and presented to the Commission at that point, and I was surprised when I looked at -- when I realized it had been a year-and-a-half. It seems like it was just -- I was thinking it was just last September, but it's been a little longer ago. So some of you weren't on the Commission at that point.

So I want to just give you a brief status update on the Hospital Discharge Data System and then talk a little bit about this is different or similar from an All-Payer Claims Database.

So I think -- I'm going to assume that everybody read the policy brief and my paper, which -- and not go into too much detail about what's already been given in writing, but I do want to point out that the hospital industry is the only provider group that has entered into a voluntary agreement with the State to have a data reporting system. We've been doing this since 2001. And so we do truly have a longitudinal data system of hospital discharges. It's more complete on the

inpatient side than the outpatient side, and there have been ups and downs of hospitals coming and going because it is a voluntary system. And the way it works is hospitals submit their data not directly to ASHNHA, but to a contracted data clearinghouse, and we coordinate the process, and it's in partnership with the State, Department of Health and Social Services. We receive a grant to help support some of the costs associated with the data system.

There have been some comments today that the hospital data is not complete, and this is true, but I do want to remind you again that hospitals are the only providers that are doing anything like this, at this point. The Physician Data System, the Surgery Center Data Systems don't exist at all, so they're even less complete than the Hospital Data System. And hospitals that are not reporting currently in the Hospital Discharge System are the same systems that will be a challenge to reporting in an All-Payer Claims Database.

And so in some ways, the challenges that we face in managing the Hospital Discharge Data System mirror, I think, the challenges that we will face as a state trying to move forward with an All-Payer Claims Database. Currently, the non-reporting -- the hospitals that don't report to the Discharge Data System are military hospitals, tribal hospitals -- except the ANMC does report, but all the smaller tribal and some of the small critical access hospitals, the mental health

hospitals. So the ones that don't report, each of them have a reason that is legitimate in their eyes, and you know, it can be argued that something makes it more difficult for them to report.

So some updates in those that do report. Since I last spoke about this, a big addition has been Alaska Native Medical Center, since they have made the transition to Cerner, is now able to report their outpatient data, which is very significant because that's a significant volume of data. Sitka Community Hospital and Wrangell Medical Center, two, small critical access hospitals, have both made a really strong effort to report and will be reporting 2012 data. We're just now -- there is a lag time, so we're just now working on finalizing the 2012 data set. Elmendorf is working on a plan to report directly to the State. They have some federal restrictions that mean they can't report in the way that other hospitals do.

So for 2012 data set, we estimate that 90% of -- the database will include 90% of the civilian acute care hospitalizations. So although it is not complete, it's -- it really is as good as we can get at this point.

So some of the -- let's see. Should I talk about the challenges or the positives first? I'll talk about the positives first.

So some positives of the Hospital Discharge Data System.

We do have all of the data on uninsured. Uninsured patients are discharged from the hospital just like insured patients and so their discharge information is submitted as part of the Discharge Data System. So that's a positive. As I mentioned, we have 12 years of historic data that's been voluntarily reported by hospitals. So we do have a good, long history. And over time, we estimate that represented about 75% of the discharges.

Another thing we're working on -- right now, we are working with the Department with Alice Rarig (ph), on a plan to make the historic discharge data available through the IBIS system. So this would take the Hospital Discharge Data and dump it into a secure data system that would be searchable, that you could do data queries on it, and we're still trying to figure out a Data Security Plan and how we can put this data there in a way that protects patients' identities and what level of detail we can release on hospitals, but this will be -- this is a way to use this set of data in way to make it more accessible. So we are committed to working with them on making that data available through IBIS. So those are some of the positives.

So some of the challenges or the current issues. We have a voluntary system, which means hospitals choose to report or choose not to, and I have no carrots and no sticks. I just have good will or I'm not even sure what I have in terms of

persuading hospitals to report, and the hospitals that report do it because they recognize the data is important to public health and it is well-used at the state for public health purposes. Hospitals recognize that the more data we have the more useful it is to them for their own market analysis strategic planning, but I can't tell them, if you don't report, this will happen, and it's a bad thing. Or if you do report, something will happen besides they get access to the data, but again, they get access to their data that they already have and some statewide reports.

So the biggest challenge right now is maintaining the voluntary system and maintaining enough participation so that hospitals will report. And notably, right now, MatSu Regional Medical Center is the largest hospital that does not report, and since they are in the Anchorage Bowl area, their lack of reporting then creates concerns among the hospitals that do report. A hospital doesn't want to put their data out there, if somebody else doesn't. It's kind of an, if everyone's in the sandbox playing, then hospitals are willing to report. So we have some hospitals who won't submit their data until somebody else submits their data, and it becomes kind of a game of wait-and-see who will submit first so the others will submit. And at this point, we are concerned that, if MatSu does not start reporting, it will be very difficult to maintain the viability of the system, that it's in a very

precarious position right now.

COMMISSIONER KELLER: If I could?

MS. MONK: Sure.

COMMISSIONER KELLER: Could you tell us why, please?

MS. MONK: Yeah (affirmative). I do not know why. I could not speak for MatSu. We have approached them multiple times. They did report, and about four or five years ago, they decided to stop reporting. We have approached them many times over the past year-and-a-half, and to be honest, recently, they haven't returned my phone calls or my emails. They have not given a reason why. About a year ago, we thought they might be thinking about it, but there was no -- so we don't have a why.

In addition, another issue -- hospitals would really like ambulatory surgery and imaging centers to also be included in reporting to the current system. As you know, many of those services that are provided in hospitals are increasingly being provided in an outpatient setting and so hospitals are voluntarily reporting, and yet, the ambulatory care surgery centers aren't reporting. So again, it's kind of an equity and a disparity, and "we'll put our data in, if you put your data in" kind of question. So it is very difficult for us, as the Hospital Association, to convince some of those other players to report.

COMMISSIONER CAMPBELL: It strikes me that you don't have

any sticks and carrots in your job. I don't envy you, quite frankly. But it seems, to me, like -- and I'm only speaking for myself -- maybe the -- using all my charm and things like that, I might be able to convince a majority around this table to ask one of our legislators to make a mandatory supporting system and that might hand you a little bit of a stick, a twig or something, just as a -- I haven't convinced myself, but I could convince the rest or a majority of the table of that, but I just throw that out as a thought, and it's on the public record now.

MS. MONK: Well, you're certainly not the first one to think of that or suggest it, and within ASHNHA, we have had some discussions about this. We haven't dove deep enough into it to have an official position, but there are hospitals that support that. There are some that are a little more wary. It's always hard, as an industry, to step forward and say yes, we want to mandate. We want mandated reporting. It's a hard thing to do, but we are looking at other states. Many states do. How could it be structured so that hospitals would feel comfortable with it and it would be productive?

COMMISSIONER CAMPBELL: Well, in full disclosure and wearing a former hat for many years as a hospital administrator, I know exactly how they feel, but also, my personal feeling was that I always -- as small as my statistics were in a small, rural facility, I always submitted

to the American Hospital Association Database because I wanted to know how I stacked up, just so that I had something to talk to the medical staff about because they had nothing else to talk about (indiscernible - voice lowered). It was about hospital stats and diagnosis, what they were keeping (indiscernible - voice lowered), et cetera, et cetera, and if I didn't know that, I was just totally flying blind. And so it seems, just from -- it always seemed, to me, from a selfish standpoint, that the more information you had the better off you were, and I always looked at (indiscernible - voice lowered) the people who were escaping the system, the surgery centers, radiology people, and things of this nature. They tend to take all of these nice, creamy profits off of the 24-hour facilities, and leave them with the high cost (indiscernible - voice lowered) and that always struck me as not exactly level. And so I come from that (indiscernible - voice lowered).

MS. MONK: I think many hospitals would agree with you, and if a mandate was being considered, hospitals would certainly want to have an equal playing field and to have the surgery centers included and that would certainly make it an easier pill to swallow, if that was the decision that was made. So that's something we are willing to talk about and we are already talking about internally as a way to strengthen the Discharge Data System.

So one of the things, I think, as you talk about All-Payer Claims, to kind of go back that direction, is to really look carefully at what are the differences. A lot of people just think, well, All-Payer Claims Database, that's the same as Discharge, or once you have that, do you need the Hospital Discharge Data System? And they are different, and I do think it is important to understand, you know, what they both -- what -- how the Discharge Data System is different, and if hospitals quit reporting to that because there is an All-Payer Claims, what are we giving up and what are we losing?

So I did work to put together a few of the kind of strengths and weaknesses of each that outline, in this handout, a little bit of the differences, and I think the big strength of the Hospital Discharge Data System is it does include all discharges in the data set, including uninsured and self-pay, which is something that All-Payer Claims does not, and it is a very -- there are national standards that have made the data that is reported by hospitals very consistent across the country. So now, there is a national database through H-CUP, the Health Care Utilization Project, that combines discharge databases from all different states into one central, and the reason the data is consistent is because they use a uniform billing form, the UB-4, as the standard data that's report. And so that means the data that's reported by one hospital is reasonably consistent to

that of another hospital in Alaska or in another part of the country.

Some of the -- the way that the discharge data is used, one of the main uses is for public health purposes, as Andrea talked about this morning. It is a very important source of data to public health. It can also be used -- there is significant information on healthcare charges, not on cost. So it's what a hospital charges, which, as everybody knows, is not the same as the price or what is actually paid, but that information is available. It does not include the amounts paid. It does not include any kind of clinical record information, what are the test results, just that the test was provided. So by itself, it only presents part of the picture.

Let's see. So I guess I would just urge you, as you move forward, to think about the challenges that we have faced in Alaska with a Discharge Data System and how they will mirror some of the challenges that would come with an APCD We have a lack of capacity to turn data into information and knowledge. Right now, the State has maybe a quarter FTE of a data analyst that spends time analyzing the discharge data, and it's not enough. So when there was mention in one of the presentations -- I've been notes this morning -- of the lack of -- there was a mention of a lack of resources, and a lot of that is somebody to take this wealth of information and actually turn it into knowledge that could be used, that is not available.

And so I would be wary that, with an All-Payer Claims Database, we could just have another system with a lot of data and a lack of capacity. There has been a lack of resources to support the data system. ASHNHA gets about $80,000 a year, and the bulk of that, about $65,000, goes to pay the data clearinghouse, and the rest of it covers a little bit of my time. I think less than 10% of my time over the course of the year is paid to do this, and it accounts for maybe 50% of my headaches over time. And I think the biggest -- the exclusion of certain types of providers -- and I think that will be a really big obstacle that we'll face with an All-Payer Claims Database. Federal, various people, and types of providers or facilities being excluded or not participating will contribute to the same challenges that we faced with the Discharge Data System.

So I think that's all I have. I'm happy to answer any questions.

CHAIR HURLBURT: Any questions for Jeannie? Jeff?

COMMISSIONER DAVIS: Thanks, Jeannie. I think I asked you this a year-and-a-half ago, but I forgot the answer. It is just the Department and the hospitals that have access to the current data system or who else might have access or not to it?

MS. MONK: Through the State, people can request special reports, and it is kind of -- it depends on what it is and

what data is being requested and how much time it will take and whether they have the capacity to do that. Hospitals can request special reports through Heidi. We have a Data Use Agreement. That means any hospital that is submitting data can request a special report within the data guidelines, but an outside entity that isn't submitting data -- so you know, MatSu, who isn't submitting data, can't come and request a report. So that's to kind of give people who are submitting a benefit.

Through the national H-CUP Project, the data is available. Alaska's data is available on a national basis. That's primarily for research purposes, and we've just approved an infectious disease research project that will be done on a national basis by CDC that's looking at infectious disease hospitalization rates, comparing Alaska Natives and non-Natives, using that data set.

COMMISSIONER ERICKSON: Can I just contribute? Jeannie, you mentioned, a few minutes ago, that you've been working with the Division of Public Health on making some of the data available through IBIS and so that's one effort, I think -- I think it was Dr. Fenaughty who, this morning, mentioned the lack of analytic capacity that's been -- that, I think, in part, has contributed to probably a lack of support for doing more to support the Hospital Discharge Database because the hospitals have been contributing this data voluntary for years

now, but there hasn't been enough produced to demonstrate for the public and policymakers some benefit to having it, but now, this new IBIS system that the Commission recommended of years ago that's just going to get off the ground here soon and the work that Jeannie referenced a minute ago between ASHNHA and the Division of Public Health to include hospital discharge data through IBIS, is going to provide a public portal for the public to be able to access and generate some aggregate reports on statistics from the Hospital Discharge Database. And so both, in part, address the problems of the lack of staff who have the analytic capacity, because they'll be able to run -- there will be an IT system in place that will provide some of that analytic capacity as well as the public portal to make it easier to access.

CHAIR HURLBURT: Yes, Wes?

COMMISSIONER KELLER: On this one policy paper, it says that there was some -- you were exploring, with H-CUP, a new agreement, and did that happen?

MS. MONK: That happened about a year-and-a-half ago. In fact, that had already happened when that report was published. We signed an H-CUP agreement and have been contributing Alaska's data the past two years, 2010 and 2011.

COMMISSIONER KELLER: A follow-up on that, did they require admission diagnosis as part of the new -- did the database charge to include the admission stuff?

MS. MONK: We have not changed the database. So we -- what we're submitting was what we were already collecting. We didn't change what we were collecting from hospitals.

CHAIR HURLBURT: Any others? Let's take about a ten-minute break again and then Linda Green will come back up here, and we'll talk about price and quality transparency and public reporting with some examples of what's happening in other states.

1:58:13

(Off record)

(On record)

2:14:07

CHAIR HURLBURT: We're having such a good day that we're running a little behind, and what I'm going to suggest is that we not have the next break and that will pick us up, give us 15 minutes so that, if folks are thinking about the break for coffee or getting rid of coffee or whatever, just go ahead and do that, and we'll plan to go on through.

So Linda Green is going to be leading us again in this next session, and Amy, I think, is online. Amy, are you online, Amy Lishko? Maybe not. So we want to talk about price and quality transparency and public reporting, which we have been leading right into.

MS. GREEN: Thank you, Dr. Hurlburt. We don't seem to have the exact, perfect slides up right now, but you do have

these on paper. So this portion of the session is devoted to looking at other states' efforts to improve and enhance transparency for healthcare cost and quality. What we -- and this begins on page -- on slide 27, I believe, of the deck that you have.

So we know that there are different models of data sets. There is research data, and there are policy reports. And we know that we want consumers to be more engaged in healthcare decision making. Val?

COMMISSIONER DAVIDSON: So if folks are looking for it, it's after tab two, and it's a continuation of the slide deck from this morning. And so if you turn to page 14, you'll be right where you need to be.

MS. GREEN: Thank you, Val. I appreciate that. So states have done a variety of initiatives about healthcare quality and cost transparency. The data sources for these reports vary. Some use Hospital Discharge data. Some use APCDs. Some use quarterly data sets from other sources. The important thing is that there are number of activities going on right now.

So moving to next slide, the Federal Health Care Reporting Initiatives. So we wanted to take a look at -- sort of survey the literature on what's out there on transparency so far, and there are a number of federal initiatives out there. Hospital Compare, for example, is a patient survey

using information provided by patients after their hospital experience. If you have ever gone to the hospital, you probably have gotten one of these surveys. There are also quality of care measures created from Medicare data.

So I just want to point out a little disconnect there in the data sets, another sort of inside piece. The data for the surveys is the entire population. The quality of care measures are based on the over 65 Medicare population. So again, a little bit of disjoint there.

The ACS, the American Community Survey, is part of the Census and talks about access to care. Do you have insurance? Do you have a primary care doctor?

There are also NCQA standard measures that are based on clinical and administrative data. Most of us are looking at those these days because of patient-centered medical home and other initiatives looking at reimbursing for quality and other performance initiatives.

The AHRQ tools for quality measures are standard analytical tools that are free, that can be downloaded to an analyst's computer and run on, usually, HDD type data with -- that's organized in a way according to the tool set.

State-based transparency initiatives. These offer consumers information to support choice of medical providers and settings. These initiatives have been initiated by state legislatures, non-profit organizations, or even the commercial

market. Again, the data sources vary. They can be from APCDs, special data calls, hospital discharge data sets. Some of them could be based on the commercial market data sets, like MarketScan and the Health Care Cost Institute. Some of them are statutorily mandated and require these data sets or reports to be submitted to the state, and we'll go through those.

So what kinds of reports are there? Well, one set, one category is reporting hospital charges to the state, usually based on hospital discharge data sets, and quite a few states do this, from Arizona to Wyoming. The charge data is, as you know, differs from the cost that the consumer experiences or even that the insurer pays. So we want to be clear that this gives you an order of magnitude. It might be comparable to show which facility is more or less expensive than another, but it doesn't really tell the consumer much about what they will pay, and as we've heard, there are some limitations to the current hospital discharge data here.

In Louisiana and Michigan, there is a voluntary reporting process going on. Michigan only requires Medicare data to be reported. Louisiana, I believe, is partially regional, and they are looking at an alternative data submission process that will -- I believe it's voluntary from the major payers. So they're actually not going to rely on their hospital discharge data going forward.

This is an example from the Wyoming Hospital Association. Hard to see. I apologize. Most of these screen prints and onsite displays are very hard to show you on a PowerPoint, and I recommend that you go look at them yourselves. This one compares several hospitals against -- it compares the Wyoming Medical Center against all hospitals in the county to any Wyoming hospital with similar patient volume and to all Wyoming hospitals. It shows some volume statistics, length of stay, charges, charge per day, median charges. This is what the state requires. This is the Wyoming Hospital Association website.

So where would we get to a more consumer-friendly perspective? Well, we want to know, really, what the consumer might actually be charged and would be paid for by a combination of consumer or patient contributions and the insurer. So these use claims data to calculate average costs or median costs, looks at all services, uses all hospital inpatient and outpatient admissions and procedures in Massachusetts. So their website, which we've shown you, is the "My Health Care Options" website, and it shows these selected procedures.

In Colorado, there is a requirement separate from the APCD to do the top 25 procedures based on carrier reimbursement. That's kind of a different take on it. And Minnesota requires a public reporting process for 103 common

procedures. Yes?

COMMISSIONER PUCKETT: That top 25, is that based on the number of times that that procedure was submitted for cost?

MS. GREEN: I believe it's based on the total amount that the carrier paid for those procedures.

So here's another screen shot, just to give you the look, and we've shown you this before. This is the New Hampshire Cost Estimator. A user puts in his or her particular health plan deductible and co-pay, and this will return what the patient could expect to pay, based on that information. So I did knee surgeries, arthro knee surgery because I decided we're a young, active group, and we'd all want to know about knees.

So the next group of transparency initiatives are those from non-profit or commercial resources. These are organizations that have gotten access to large databases and have the capacity to organize, analyze, and report on them in ways that have found a market. So the non-profit organizations include the Health Care Incentives Improvement Transparency Report Card, which recently released reports for 2010, 2011, and I believe, 2012, looking at trends in procedure costs for -- based on payments by the major national insurers, such as Aetna, United, maybe WellPoint, but I don't -- I'm sorry. I'm blanking on that. There are four of them. One is Kaiser, and they have limited information. Only their

fee-for-service data is in there.

Leapfrog does hospital quality reporting. That's an interesting approach they have. The hospitals pay for the privilege of filling out a very detailed questionnaire about their performance and then Leapfrog turns it around and analyzes it, but it got a lot of traction because a number of payers required this set of metrics, this set of reporting and tied it to the hospital reimbursement level.

Consumer Reports is also starting to do some quality reporting in states where they can get sufficient data to do accurate and reasonable analysis of the data.

On the commercial side, there is a growing interest in reporting this data. Angie's List has a list of recommended providers. In terms of the more employer-based reporters, there is Castlight, Change HealthCare.com, and the HealthCare Blue Book. There are *U.S. News and World Reports* hospital and health plan rankings that are periodically splashed into the media. There are JC Powers surveys, and there are health plan' members-only websites, including Premera, which should have been listed. It was left off; I apologize.

I think the thing to remember here is that these commercial organizations are not required to be especially detailed about their methodologies. I heard one -- reports about one of these commercial entities, and the folks who had heard it -- Kim was saying, "They just go with bad data. They

don’t care if their data is bad. They’re just intent on doing their ratings.” And this was among a bunch of data folks, and they were not pleased. Kind of scandalized, as much as data people can get scandalized.

So the takeaway here is that the commercial folks seem to have created way that gets people’s attention about this information, whether it meets all our other criteria that it’s actionable, credible, transparent, not as clear, but we can take lessons away from the commercial data displays about how to make ours more interesting, how to make it accessible, and how to get the message out using a more rigorous methodology.

So I am at the -- that was quick. Do you have any questions on this? Yes?

COMMISSIONER HIPPLER: Thank you. In the second-to-last slide, the New Hampshire Cost Estimator, was that Cost Estimator provided by the state of New Hampshire in association with its All-Payer Claims Database?

MS. GREEN: The data source is the All-Payer Claims Database. The methodology was created by an analyst in the State Division of Insurance, who knew how to do some programming.

COMMISSIONER HIPPLER: It’s pretty neat.

MS. GREEN: It is pretty neat, and I believe he makes the software, the coding available to states that want it.

COMMISSIONER HIPPLER: I guess, as a follow-up, you know,

the estimate -- you've estimated the cost at somewhere between $1 and $1.5 million to establish an All-Payer Claims Database. Assuming that that were the case, once we had established that database, would we have a final product as useful as this slide that we're looking now?

MS. GREEN: The answer is it depends. It depends on the willingness to pass legislation that requires standardized data intake. It depends on the scope of your rules and regulations to bring the data in, in a timely way, and to adhere to established standards. And it depends on the working -- the collaboration with the payers to get the data in. So yes. The answer is yes, if it -- it's more than just a technical issue of -- can we do this with the standard APCD data? Absolutely. New Hampshire is not one of the more complex APCD states. They're pretty baseline. They were one of the first ones out there, and their data can't do some things that we have come to wish it could do, but it can do this.

COMMISSIONER DAVIS: So just a comment. What we found that this kind of display is what people want to see, and it's useful, and they make decisions based on it because it says -- it tells what they pay, and at the same, gives the range and shows the options. So if this were the output, then I can see utility in that.

MS. GREEN: Jeff, can I ask -- I have not seen your

members-only website because it's members-only. What else does yours -- does a members-only website provide that would augment something like this?

COMMISSIONER DAVIS: I think the only thing is that, in some cases, we have some reported social media type quality indicator, or if there is other publicly available stuff, that it's also reported, but it's, essentially, this is what we're after.

MS. GREEN: Thank you. Was there a question? Yes?

COMMISSIONER URATA: Sure. I'll ask it. I'm just wondering, why the large variation between Alice Peck Hospital and Dartmouth? And then it says insurance will actually pay that big difference? Is that my understanding? Is that because there is different insurance or is it the same insurance paying the two different hospitals different? And I don't know if you can answer that.

MS. GREEN: According to the way that I pulled this particular example, I selected Anthem Health Plan of New Hampshire, just because they would give me this information within a particular zip code, and I slugged in, you know, a deductible and co-insurance of $800. So that's why they're $800 in every instance in the first column. The second column is the total allowed amount, minus $800 and that's what the database showed.

Now, here's what I don't know for sure is whether the

complexity of the patients has been reflected in these amounts. Have they been standardized? So you can see that they have some discussion of that, but if I were -- I might actually run this through some sort of illness burden analysis so that I wouldn't have to figure out that the numbers were, you know, higher. I would say, all right, so $6,700, that's because it was high complexity, but I really don't know why the middle one is low complexity. It doesn't make sense. And I think though that that's one of the things that they found when they did this, that it did not make sense.

COMMISSIONER URATA: Thank you.

(Pause - background discussion)

MS. GREEN: I had summarized them for you in these slides and tried to group them, instead of trying to go state-by-state, but happy to discuss more of them, if that's something you'd like.

(Pause - background discussion)

CHAIR HURLBURT: So you've spoken well of New Hampshire a couple of times, which geographically is very different, but population-wise comparable to Alaska. And do they have a dominate insurer? Is Anthem dominant in the market there?

MS. GREEN: Anthem is quite large there. There are three or four other large insurers who operate there.

CHAIR HURLBURT: And does the State, as an employer, participate there, and do they self-insure, do they have a TPA

arrangement, or do they buy insurance?

MS. GREEN: Great questions. I'm not familiar with how New Hampshire provides coverage to their employees. I believe.....

CHAIR HURLBURT: I'm just looking, what are the similarities between (indiscernible - voice trailed off)?

MS. GREEN: I think the similarities, as you mentioned, are size. I think that they also have diverse region -- that the regions are not the same, that there is -- the southern part of the state is, essentially, a suburb of the Boston Metropolitan area. The northern part of the state is the Dartmouth area, and in between are mountains and ski resorts, which have a transient population. So I think that, in that regard, it has some similarities to Alaska. I think that they are also very tightly staffed in state government. They are also very interested in why the cost of healthcare continues to increase. They're currently doing some studies with their provider community to understand how -- in that case, how contracting affects their pricing.

CHAIR HURLBURT: And how long has a chart, like the one that was just up there, been available through the All-Payer Claims Database?

MS. GREEN: It's been available for about three or four years. Amy, can you talk a little bit about what you know about the New Hampshire website? I guess she didn't.....

MS. LISHKO: Can you hear me, Linda?

MS. GREEN: Oh, here you are. Thank you.

MS. LISHKO: Yeah (affirmative). I couldn't tell if my mute was on or off. I think you are correct. It's been around three or four years, and it really was the initiative of one staff person who, you know, they were talking, much like Alaska has been talking, about price transparency, and he took the initiative. There was really nothing out there to model it on, and he was really ahead of the curve as far as all of the smart phone applications and things that are coming around now. So they, basically, are modeling their applications on a lot of what his program does. I think that the (indiscernible - voice lowered) is one that was already mentioned in that there is no quality data. So while residents can compare costs, they don't really have a sense of whether they are going to receive the same quality. So that's, I think, the biggest limitation to that data set right now.

CHAIR HURLBURT: So information, like Leapfrog data, is not readily available and widely used or is it?

MS. LISHKO: It's available, but you'd have to then, you know, (indiscernible - voice lowered) is primarily structural data. Does the hospital have a computer-ordered pharmacy program? Does it have Electronic Medical Records? It's the kind of structural factors in a hospital, and if you're

looking particularly at a diagnosis or at a procedure -- I'm going to go in for knee surgery or bariatric surgery -- there may not be a quality measure available for you to be able to see how the hospital scores on that particular procedure.

CHAIR HURLBURT: So you can't go find out what's your 30-day hospital mortality rate for a CABG or your readmission rate. So if they've had it for three or four years then, have you gotten any sense from, say, Anthem, if they're the large payer there, or others, do they feel that having this information available to consumers and to payers, has that had any impact, subjectively or objectively, as far as cost?

MS. LISHKO: I think New Hampshire will tell you that they can measure how many hits they even get on the website, and they are disappointed by that, and so to go further out and say there has been an impact on overall costs, I'd say there hasn't been any research done on that, that I know of anyway, but I don't think that anyone thinks that it's had a major impact. But again, it goes to the issue I was talking about earlier, which is, do enough people have the kinds of plans that would provide an incentive for them to go and look? And Linda's example, I think, is a good one because she put in an $800 deductible, and I'd say that that's probably -- it may be even a little high, but probably an average deductible for people on the East Coast anyway, and you can see where it didn't matter where that person went because the surgery was

going to be more than $800 in all cases. And so we're running into this phenomenon where, you know, if you have a deductible that's fairly low, you're still not really providing that incentive for the consumer, except from an educational perspective or wanting to save the system money, which, I dare say, most people aren't thinking about.

CHAIR HURLBURT: Have you had any chance to look at the public data from All-Payer Claims Databases in a situation where there's more catastrophic type coverage and HSA or a similar arrangement?

MS. LISHKO: I have not seen -- I think New Hampshire is the only one that has kind of really cool data set, and they don't have enough people in those kind of catastrophic plans. So I think it would be really interesting, Dr. Hurlburt, to mix those two (indiscernible - voice lowered) both and really do an experiment, have people have higher deductibles, catastrophic-like plans, and have this information available, and educate them on the availability of it. I do think consumers would use it, if there was an incentive for them to use it. Some plans are looking at giving -- I don't know if they have this at all in the West, but they're providing -- instead of, like, a penalty, which a deductible is, they're providing cash rewards back to consumers who choose more efficient providers for their care. So they incorporate a program -- the plan does incorporate a program into the health

plan, which basically says, when you get a diagnosis and you need “X,” an MRI, a lab test, a this, you dial into this number, and we will give you, you know, the five places that are closest to you that are efficient. If you go to one of those places, we’ll share the savings with you. It may be $75 or $100, and those programs have been shown to be pretty successful.

MS. GREEN: One of the things that we noticed in Alaska is that the percentage of individuals who have high deductible Health Saving Account plans is increasing over time. So that may, you know, change the landscape very soon. Those plans are taking, you know, a higher and higher share of the insured market, and in other states, we’re also seeing a big shift to self-insured plans well, which are sometimes more flexible in those arrangements that Amy was describing.

CHAIR HURLBURT: Jeff?

MR. DAVIS: If I can just add, for perspective, our most popular individual plan in Alaska right now -- popular selling is a $4,500 deductible. $4,500. Yes. You heard me right. And we see a number of our largest employers moving to all high deductible health plans, $2,000 and above, but then providing something in the way of a Health Spending Account or a Health Reimbursement Arrangement to kind of offset that pain, but you do still see the change in behavior that I described earlier. The first few of that, utilization drops

significantly.

COMMISSIONER MORGAN: I actually have a question for Jeff. Under the Insurance Exchange, I know they have Platinum, Gold, Bronze, and a Standard policy that you have, the minimum to be allowed to sell insurance in the Exchange. So I got that right. So are high deductible plans allowed in the Exchange?

MR. DAVIS: Well, to answer your question maybe not directly the way you're asking it, $4,500 is a much higher deductible than the minimums that are going to be required in the Exchange. So you may have read or heard me speak on the impact of the Affordable Care Act on individual plans, and our actuaries are now estimating average premiums going up 21% to 79%, and a big chunk of that is the richer benefits because what is required to meet the minimum coverage standards is a lower deductible than that's in the market today. There are plans though, like the Barnes plans, that could be matched with an HSA plan and that's still allowed. So yeah (affirmative). It doesn't do away with them, but it does -- it moves the richness of the benefits, the long way from a cost perspective and a utilization perspective.

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: Can you say that last part another way? I had trouble -- I understood and then you said

that last sentence, and I.....

CHAIR HURLBURT: The richness of the benefits part?

COMMISSIONER DAVIDSON: Yeah (affirmative).

MR. DAVIS: So if the issue is -- the big beta issue is sustainability because of costs, and you know, we've -- Dr. Hurlburt held up the graphs this morning, and I've got similar ones. Moving from a market standard today, which is a $4,500 deductible, to a minimum deductible around $2,000 is likely to increase utilization, therefore increase the cost problem rather than decrease it.

COMMISSIONER DAVIDSON: Thanks.

MS. LISHKO: Yeah (affirmative). I think Linda's example of the $800 really illustrates that nicely because, you know, it's that deductible. You know, if someone had a $2,000, there really wouldn't be an incentive for them to shop around.

MR. DAVIS: I think, Amy -- this is Jeff Davis -- that what you're pointing out is true. There is a point in time in which people are 100% covered and their desire to shop goes away significantly, but it's still true that the first part of the spend is -- and where people have a higher deductible and a spending account and it's there money -- I mean, it's been consistently shown that you do get significant changes in behavior. The number I've seen most often is about 30% reduction in healthcare consumption the first year you put in a plan like that. So your comments are absolutely correct,

but there is the other end of the spectrum where it does seem to have an effect.

MS. LISHKO: Uh-huh (affirmative). Yeah (affirmative), for the smaller, prescription drug -- specialists, things like that.

MR. DAVIS: Sure. Mr. Hanson's example of the MRI.

MS. LISHKO: Uh-huh (affirmative).

MS. GREEN: Amy, this is Linda. Could you talk a little bit about the effects of the transparency initiatives that you worked on in Massachusetts before the All-Payer Claims Database?

MS. LISHKO: So that was, basically, very similar to the website that Massachusetts has now, but it was initiated by Governor Romney to create a more transparent environment of both healthcare cost and quality. I have always been a fan of having consumers have as much as possible. So we moved forward with putting any data and information that we had available on the website, including things like volume of surgical procedures by surgeon, and we tried to get as much information as we could to help consumers be able to have access to that information, particularly if that would be difficult for them to ask of a provider, such as how many of these surgeries have you done in the past year, things like that. So we did move forward, but it (indiscernible - voice lowered) with every issue that we didn't have our arms around

because we only had the HTD data set. We didn't have an All-Payers Database. So we didn't have the outpatient piece, and it really was very difficult to look at the procedures that were done, both on an inpatient and an outpatient basis. So I think the All-Payer Claims Database helps for being able to look at sites of care for various procedures, hospitals versus ambulatory care surgery centers, things like that, that you can't get if you just use a Hospital Discharge data set.

MR. DAVIS: So, this is Jeff again. I would just like to go back to something, Amy, you mentioned earlier and that we're experimenting with and haven't gotten there yet is paying people to become informed medical consumers, if you will. So it takes away this issue of I've got my deductible, but I need something, and I make a call or I go visit the Web or do whatever I'm supposed to do to get informed about my choices, first of all, what is it I'm looking at, what are my options, and then cost and quality transparency, to the point you have it, to the degree you have it, comes in at that point. It looks like there is going to be a "there" there, that there is going to be some success with that, and if you -- you know, if 30% is waste and if 30% reductions are seen when you give people a stake, and if you pay them to do the right thing, which is figure out and do the research Mr. Hanson did, hopefully, in a much easier way by making a phone call before they get the thing done and they share in the

savings, that there is some potential there. So two points to that one is you have to have the data -- I mean, we do, but others don't. And so if you're looking at statewide perspective, then that argues for a credible data set. But then the second is, kind of, maybe this is a different way of thinking about what can be done with it, not a website, not what the state does with it, but what, you know, Mr. Puckett does as the steward of his health plan, or you know, how that gets rolled out and maybe it has utility in that kind of way that's different than what we've been thinking about, not just a website, but can it then drive other programs, like the one Amy mentioned.

CHAIR HURLBURT: Philosophically speaking, I know and I've had plenty of experience with paying people to do what's good for getting the results that you want, whether it's having people get mammograms or well baby exams or something, and so you pay them to do that, and it does the right thing. It gets you healthier people, and it reduces your healthcare cost, but if you're an employer and you're paying for healthcare and they get Premera, for example, to do that, as you pointed out this morning, you really are a non-profit company in terms of what you really make, but there is a little bit of friction with the money going through Premera, and it costs you something to handle that. And so as far as really wanting to -- believing that, in a market-based system,

if individuals have some skin-in-the-game to have their interests coincide with the health plan or with the insurer, like we heard with the example last fall, just philosophically, is that really the best way to go or is it -- and that may be the only way we go can, say, under the Affordable Care Act, whereas you point, there is a restriction, a limitation on how high your deductible can be. But to go back to a time when we really did have catastrophic insurance for people, but we didn't have the first dollar pay or close to first dollar pay that we have now, is that really the best way to do it? And that's just kind of a philosophical question, but I wonder.

MR. DAVIS: Well, I don't know if it's the best, but I know that it works, and I haven't seen anything else, at this point in time, that works quickly and effectively over time, but yeah (affirmative). You would want people to do the right thing, and they often do without any incentive, but everyone is busy and if I can, you know, find a way to get the care I need and also, you know, get a little extra reimbursement on top of it for being an informed consumer, I'm more likely to do it than not. So I don't know if it's the right thing, but it does work.

CHAIR HURLBURT: Yes, Val?

COMMISSIONER DAVIDSON: So as long as we're being philosophical, isn't a part -- I mean, I guess a part of it is

how we characterize that payment, and isn't that really more accurately described as a refund of a part of the premium that has been paid on their behalf? I mean, it would be like me saying I filed my taxes, and the IRS paid me to file my taxes, when the truth is it was my money to begin with, and I got the refund from the amount that I overpaid. So really, if we're calling it what it is, it is a refund on the premium that has already been paid on behalf of a beneficiary. Whether that's paid by the employer, whether it's paid by the employer and the employee, it's a refund of what has already been paid, and we should call it that.

CHAIR HURLBURT: Yes, and I would absolutely agree with that. And what I wasn't clear about and what was in my mind was that, if the employer didn't have to pay so much for the insurance premium, the employer could then pay the employee a higher wage, and there is not then the friction of that going through Premera or through Aetna or whoever. So you might say, well, they're not going to pay the higher wage; they're just going to put in the employer's bank account. But I think that the high insurance premiums really have been an inhibition on the ability of employers to raise wages. So that would be my response, but I think you're right. In that context, if you are paying the high premium, yes; it is a return of a small portion of the premium. Allen?

COMMISSIONER HIPPLER: Thank you, Mr. Chairman. I have a

question for (indiscernible - voice lowered). I am wondering, in light of this conversation about incentives and responsibility, we've been talking about New Hampshire, and would you characterize the population of New Hampshire as a larger proportion of private insured and people have to pay for their own healthcare as opposed to Alaska, for example, with a proportion of VA and tribal? And I don't know how Medicare and Medicaid stack up between the two states, but what I'm looking for is, do you think people in New Hampshire are more likely to respond to price transparency because it's meaningful to them as opposed to in Alaska? Thank you.

MS. GREEN: Amy, would you like to take that one?

MS. LISHKO: I think the percentage of privately insured is higher in New Hampshire; that's true. Fewer government programs, but given what Jeff just mentioned about the average deductible in the marketplace, I would say that that's higher in Alaska than in New Hampshire.

CHAIR HURLBURT: Any other questions or comments? We actually are at 3 o'clock now. Is your preference to take a 15-minute break or to continue on and maybe finish 15 minutes early? Okay, Deb?

COMMISSIONER ERICKSON: I'm okay, if everybody else is okay.

CHAIR HURLBURT: Linda, thank you very much, and Amy, on the phone, thank you. This has been very helpful.

MS. LISHKO: You're welcome. Thank you.

CHAIR HURLBURT: So the way we're going to spend the rest of our time together this afternoon is just with some brainstorming, and I was thinking -- and maybe this will only be helpful for me, and if nothing else, hopefully, it will be helpful for some of our newer members, but I thought maybe it would be good to just take a few minutes and back up a little bit and talk about the context behind why we've been working on and having these conversations today, especially for our newer members.

And what I'd like to do is refer you to a document that you have behind tab three that looks like this, and it's on the website. For those of you who might be listening on the phone, it's titled Core Strategies and Policy Recommendations, and this was my effort. I don't know if you remember, last year for our 2011 report, I created a two-page handout for legislators to have just a very brief summary of our findings and recommendations from that year, and in an effort to boil down the pages and pages we had of our approved Recommendation Statements, I had synthesized them into those solutions or core strategy statements that have evolved to the cover of this sheet now, and I added the two that we discussed and worked on this past year related to end-of-life care and also the engagement of employers in improving health plans and improving wellness are the two new core strategies added this

year.

And then something I want to talk about at the end of the day, or at least, plant the seed for a continuing conversation over the next couple meetings is getting feedback from you on how the way I'm characterizing it can be improved, if you feel as though I'm not fairly or accurately summarizing in these couple pages our eight or ten pages that we have now of the body of policy recommendations that you all have made over the past few years.

So I'm referring you to this document because it's a good, if nothing else, cheat sheet for all of the recommendations we've made to date, and there are two areas that I wanted to point out. One is on page three of that document and that's the section where I've captured the recommendations that we've made in the context of having conversations about price and quality transparency in the past years.

And then the other is on page ten, and it's related to the health information infrastructure where we have identified a series of strategies. I mean, part of our approach to our planning process has been to not only identify some specific strategies where we can identify policy recommendations for improving the quality and the affordability of healthcare and focusing on what will work best from the consumers' or patients' perspective, but at the same time, we were

identifying kind of the foundation of ideal -- the perfect healthcare delivery system and having an appropriate workforce and the sound health information infrastructure in place and then the policy and statewide leadership piece of that foundation. And this is -- I actually don't have the current, but I was able to quickly find an older copy of some diagrams that I put together at one point for some past meetings on what we were thinking about and what we've discussed as the components of the health information infrastructure, that it is -- you know, all of the data that goes into -- and you need the technology and the workforce support, some of the issues we've talked about today, whether we have the analytic support, whether we have the tools or not, and all of those are used within a certain policy and reimbursement environment and framework and that, ideally, you have all of those pieces that you need and the proper environment to turn it all into information that's usable and that is actually used for improving health and quality of care and improving value.

And so we've talked about some of those uses and that was -- the panel presentation we had today was meant to kind of continue that conversation about how clinicians and clinical settings are using information for improving the quality of clinical care, how health plan administrators are using data now, and what they foresee for the future for making improvements in health plan design, and how public health

officials are using it, how government policymakers are using it. Dr. Fenaughty shared how some community leaders are using data that's becoming increasingly more available for community health planning.

And then one of the things we've been struggling with -- and Mr. Hanson, in his presentation during public comments -- the real issue that we have to remind ourselves and want to stay focused on periodically is what's really working best for individuals and patients and consumers and how can they use that information.

So again, just kind of in that context, we have a whole bunch of recommendations that we made a few years ago that I think, for the most, are still current and are being implemented related to the technological piece around Electronic Health Records, the Health Information Exchange, especially, telemedicine. We continued that conversation last year.

But two of the pieces that we had identified in the past years where the data sources had some gaps were the Hospital Discharge Database and the fact that we didn't have full participation in that, so it wasn't as robust as it could be, and the All-Payer Claims Database was a question about whether that was something that we would need.

So related to the health information infrastructure, we have those questions out there, still, related to the All-

Payer Claims Database and the Hospital Discharge Database. And then related to price and quality transparency, I'm going to get out of this presentation and get ready to start capturing some of your thoughts.

So on page three is what we had really done initially, and when we were having the conversations about price and quality transparency, it was related to those two data sources that, you know, may or may not be the ideal supports for public transparency for price and quality, the Hospital Discharge Database and the All-Payer Claims Database. So we have those two recommendations that we study an All-Payer Claims Database, that the State encourage full participation in the Hospital Discharge Database. We had stopped short, at the time, of recommending a statutory mandate with the understanding that we might reconsider or consider that question again in the future, and we are, this year, in the future -- not today, but continuing that conversation now.

And then with our learning around employer engagement, we, just this past year, had identified the importance, again, of making that information available to the patients, the consumers, and provided a little bit more of a recommendation related to that.

So we have -- and then just one more background piece. When we prepared the RFP for the study for the consultant contract that we awarded to Freedman, I didn't want to just

ask whether the State should have -- what is the feasibility, and can we make the business use case for an All-Payer Claims Database, understanding that the reason the Commission was interested in an All-Payer Claims Database in the first place was around the transparency question, and also, we had learned about payment reform. And one of the factors that we had learned about payment reform was having a common data set that both payers and providers could trust and could use to get -- I think Dr. Acarregui this morning mentioned that, at some point, we just really need to start moving towards paying for care in a different way, and there are going to have to be some real tough conversations about risk sharing between payers and providers at that point. And so I mean, to that point, we thought, well, maybe an All-Payer Claims Database would be a data tool that could be shared for that.

So the question to the consultants wasn't just whether an All-Payer Claims Database is something we should pursue or not. The question was, are there other options to get at the Commission's goals? And I think that was one of the reasons why Freedman and Linda, in her presentation this morning, showed that arrow and the different options and the different steps we could take.

And then as well, the other question is, are there other ways to get at transparency? And so we had asked them to include, in an appendix, this inventory that you have now in

this report and the presentation in which Linda just summarized it, what some other states have done, as examples, in state legislation to get at the transparency issue, provide some solution for the public related to that. And so while there are some examples in here around All-Payer Claims Database legislation, and we certainly have the examples from all the states now that have All-Payer Claims Databases, if we were to go in that direction, it's something to draw from, but then again, in Mr. Hanson's public testimony earlier, I think he was highlighting, for you, some other opportunities to impose mandates on providers to make their prices more transparent for their patients.

So we have a couple of issues related to transparency. One is the data base issue, Hospital Discharge and All-Payer Claims Database, and then these other opportunities for potential mandates on providers for public transparency. And then for strengthening the health information infrastructure for those other purposes in addition to transparency, other uses for improving health and healthcare, the question about Hospital Discharge and All-Payer Claims Database. So there are all of these puzzle pieces that are fitting together to support our different strategies and issues and questions, and I don't know if that's all as clear as mud or not, but it might be helpful to provide that background for our new folks and remind everybody of the context before I turn it over to

you.

And what I'd like to do is what we have done the past few meetings is just spent some time at the end of the day capturing your preliminary thoughts about what you feel that you've learned today that you would want to capture in a Finding Statement eventually and then some preliminary thoughts about potential recommendations. And we will spend some time between meetings, through email and perhaps a teleconference or two and subsequent meetings, in refining those and seeing if we still have some major questions before we answer them. Does anybody have any questions about process before I stop talking and let you take over? Yes, Dave?

COMMISSIONER MORGAN: This may be -- I may be digressing a little bit, but this is a question. I was in Juneau two weeks ago, not representing anybody but me. I was (indiscernible - voice lowered) down there with another organization, but visiting with the Legislature. And this is more of going back to this document, the document of what we've done, and I will tell you that I talked to 12 legislators, and four of them Chairs and Vice Chairs of both Houses, and Lieutenant Governor and the Governor. They both mentioned -- all six mentioned they did read our reports and then did have some -- they were very interested, and it did -- you know, they did feel like they were having interaction. I was going to ask you and Wes -- I mean, that's a minority

though. It's the guys you see talking a lot on Committees, but the impression I got was that, but I want to reconfirm it, that this is what they're wanting. I mean, you guys interact. I mean, the things they'd like for us to be doing and the activities and that they'd like to reporting to -- I'm talking about the Governor's Office and the Legislature. So it does tie to this, but it's more of, are we delivering what they expected and what they wanted to see? And I know they're timely because I watched on TV, by the way. You look thinner on TV. No. I'm just kidding. I'm just kidding. On the screen. But is that your impression, Wes? I think you're in Legislature.

COMMISSIONER KELLER: Honestly, I've had nothing positive response from my peers, and especially after you came down this last time and presented to the "S" Committee, even though the "S" Committee was a zoo because we were coming and going. I have had a lot of people comment very positively and appreciated the information.

COMMISSIONER PUCKETT: For what it's worth for people that are higher up the food chain than I, the rising cost of healthcare has simply forced the issue on people, whether they're interested or not. They're just facing the reality. So they probably are much more engaged than they have been in the past, but I think it's because it's been forced on everybody.

CHAIR HURLBURT: And two years ago when -- for a number of reasons -- because of the reduced and the federal match, because of the loss of some ERA funding that had gone to Medicaid, but the hit to state general funds for Medicaid two years ago was $129 million, and what it felt like, to me, was the response was, oh, that's terrible. Okay. What's the next item? It didn't get much attention. But with your boss, with your Commissioner, with my Commissioner there, with what Deb and I have experienced being there, there is engagement. My bias is that the cost of healthcare is the dominant economic issue for the United States and the number two for Alaska, next to energy. And because that's so dominant -- it's like Mr. Hanson expressed -- we could end up making some horrible mistakes in a terribly important business to respond to that.

So I think that that's going to drive the change. Hopefully, as payers, businessmen, businesswomen exert more pressure, we'll see the change come. Certainly, the Legislature, both the Senate and the House, Finance Committees for HES, and the HES Committees are much more engaged in that to a person, I would say -- and you know, feeling the changes have to come, realizing that we need to be very responsible how we do it, but recognizing that the frequently used "unsustainable" is not just a jump word, but a real word. Wes?

COMMISSIONER CAMPBELL: One thing that I realize hasn't

been pointed out, and some of you may not realize, but we go down there, break into subcommittee groups, and each subcommittee takes on a division of the State, and the House works on the operating budget, and the Senate starts with the capital budget. But this year, the subcommittees were all disbursed, and there was one, glaring exception. HESS, Health and Social Services, was retained for the entire Finance Committee. So the Finance Committee, itself, is serving as the Budget Subcommittee for Health and Social Services and that just shows -- it just illustrates and puts an exclamation point on what you just said. There is a growing awareness, and I know the majority from the House are very concerned. We talk about it a lot, so.....

COMMISSIONER DAVIDSON: So where are we in the agenda?

COMMISSIONER ERICKSON: That's what I was just going to say.

COMMISSIONER DAVIDSON: I mean, (indiscernible - simultaneous speaking) the Legislature's intent because my experience is they're really, really good about declaring their intent, and they do that through Joint Resolution. They do that by Resolution of the House or the Senate. They do that by enacting law, but what they -- and if the Legislature wants to act, they can, and they do all the time, everyday. I think our job here is what is our Health Care Commission's recommendation for what our health plan and what the health

future of Alaska should be. So while we could all speculate wildly about what the Legislature wants, what they've asked us to do by statute is to come up with a plan for Alaska, and I think we probably should do that.

COMMISSIONER ERICKSON: Thank you, Val. This is -- yeah (affirmative). We did, in fact, jump to 4 o'clock on our agenda, and the brief time we were going to spend talking a little bit about our sunset audit and some other process improvement things, and it just reminded me of, if you can be patient with me again, the -- I facilitated an all-day meeting once, and one of the evaluation comments I got back was the thing the person liked the best about the meeting was the flexibility of the facilitator, and the thing the person liked the least about the meeting was the flexibility of the facilitator. So I thought I'd let that conversation go for a couple minutes, but not too far. Not too far. And this was a lot of information to absorb today, so folks maybe needed to think and talk about something else for a minute. But yes.

Now back to brainstorming, if I could start getting some ideas -- and we will continue that conversation a little bit later, but if we could just start throwing out some ideas, some of the key points about issues that you think you learned related to -- and I think, for now, we'll just mash it all together and see if I can tease it out, and if it's not working, then we'll break it up. But related to -- Hospital

Discharge data, All-Payer Claims Data, and transparency are the three main issues that we learned about today. Allen?

COMMISSIONER HIPPLER: Thank you. I learned today that an All-Payer Claims Database in Alaska would be a little different than elsewhere because, apparently, we have more federal agencies here that do not submit data, generally, to APCDs. I didn't quite understand that, but it seems like, if we want to have an APCD, we'll have to do some pioneering work.

COMMISSIONER URATA: The APCD would be a method for providing the transparency that consumers desire. Another one is the APCD would probably require a legislative statute or ruling so that important players would participate to make it valid.

COMMISSIONER DAVIDSON: I heard that the APCD would cost a lot of money. I didn't hear that -- I heard the estimate on cost, but in our experience, I mean, just noticing the MMIS system, that isn't done yet. I mean, that's been a ten-year process. The things that we do in Alaska to implement those systems generally cost about twice as much and they take twice as long. So the $1 to $2 million estimate that we heard is probably more like a $2 to $4 million estimate.

The other thing that I heard was it's really important to have Medicaid data in there, and I'm not sure how we would do that when we're still doing the MMIS system. So maybe this is

something that would be helpful to start after the MMIS system goes live.

COMMISSIONER ERICKSON: Emily and then Jeff?

COMMISSIONER ENNIS: I learned that there may be other options for providing the transparency that consumers desire, that we may have resources right now for doing that, and we might want to follow that thing.

And then secondly, I learned that we may need to have a little more time seeing the results of data. It seems like that there has, perhaps, been some reluctance on the part of providers to provide data, perhaps because there haven't been enough results that show evidence of the benefit.

COMMISSIONER ERICKSON: Can I ask for just one point of clarification? Do you think that was specific to Alaska wanting more evidence of the data available in Alaska or nationally other states' All-Payer Claims Databases?

COMMISSIONER ENNIS: Alaska.

COMMISSIONER DAVIS: And this may be similar, Emily, to what you just said, but if you were limiting that to Alaska, what I heard, with some disappointment actually, was that, even in states that have had the All-Payer Claims Database information available widely for several years, the usage has been minimal, and there has not been an ability to document a clear, positive cost reduction impact on the healthcare costs.

COMMISSIONER ERICKSON: Allen?

COMMISSIONER HIPPLER: It's a good point, Dr. Hurlburt. I heard that with a little dismay as well, that is to say the lack of affect of price transparency in New Hampshire, or the perceived lack of affect, and it seems that the reason or the speculated reason as to why that is, is because the consumers are insulated from price sensitivity. If they're not price sensitive, then they're not going to care what the prices are. So once again, we come to price transparency only matters if consumers have a stake in the outcome.

COMMISSIONER DAVIDSON: On that last -- the one that you're on, can you change "use" to "utilization" because Meaningful Use is kind of a term of art where people might confuse the issues?

COMMISSIONER ERICKSON: Yes. Thank you.

COMMISSIONER DAVIS: So just piling on a little bit to the notion that an All-Payer Claims Database is not all-payer, listening to Linda's very cogent explanation, I think that the ERISA issues, although they have been -- ERISA exempts self-funded employers from state oversight in general, and in even though in other states, there have been lawsuits by the self-funded or their administrators to say no, no, no, they have a legitimate, that sounds like an uphill schlog to me. So if we're thinking of the cost, I think we're also thinking of -- we have to think of kind of the difficulty of negotiating with VA, negotiating with all of the payers, and perhaps, fighting

on the ERISA side because self-funded administered by TBAs is a very big part of this market.

The other thing I think that was, at least, pointed out by me, amongst others, is that, if you have the data and you don't make the investment to turn the data into information, then you really haven't accomplished anything either. So that needs to be considered as part of the investment, if we go down this road. Thank you.

COMMISSIONER ENNIS: I believe we also need to look at the Alaskan consumer a little more thoroughly. We're assuming that the consumer is interested in transparency. I would be worried we don't want to generalize that too broadly. We've got some unique consumers in the state of Alaska, some of which may not really pay attention to the information that transparency would provide. So I think, you know, just understanding the nature of the consumer in Alaska is important as we are providing education and trying to gain support for the APCD

And then secondly, just a little bit of an aside, and this is just, you know, thinking about the moment in which you might have that opportunity for making an informed choice for medical care. Those situations may not be as readily available when it's going to make a big difference. Often, they aren't at times where you have an emergent situation that there is a medical crisis involved. You don't have a lot of

choice in the community you live. You have both time and emotional urgency occurring as well. And so you know, just considering those scenarios in which, really, you just want care immediately and whoever is there to provide it. So I just thought I'd mention that as well. You know, it's an unusual situation where you -- it's just one of, I guess, variability that we need to consider in that consumer transparency issue.

COMMISSIONER ERICKSON: Bob and then Val?

COMMISSIONER URATA: I think I learned, today, that transparency may help improve quality.

COMMISSIONER ERICKSON: Do you want to elaborate on that just a little bit? Was that specifically related to clinical quality?

COMMISSIONER URATA: Clinical quality of care, sometimes, Medicare's core measures and advertise, you know, the core measures and how hospitals may improve the efforts to improve quality in certain arenas of medicine, not all, but in some, and perhaps more transparency in, you know, results of infection rates after surgery, you know, success of surgeries, et cetera, things of that sort, and advertising that on the website might incentivize people to do better -- or incentivize providers to do better and be more careful and things of that sort.

COMMISSIONER ENNIS: I meant to add this, and I'm

following up on your comment. Again, the consumer who is probably most interested in transparency in cost and quality right now you might characterize as an individual who is well-informed, assertive, probably in an urban area where there is choice, and we might want to think about, in terms of moving forward for this APCD, is that -- APCD -- whatever the initials are. They're not up there now for me. Thank you. That there could be a public education plan that goes along with it to remind us and to show us how to find information about quality and cost could be part of a long-range public education program, so that those individuals who might not be of those characteristics that I've described would realize that they could have greater control and more information about this issue.

COMMISSIONER DAVIDSON: Mike Hirst did a really good job of -- and this goes to Jeff's point earlier -- talking about data, in itself, is not helpful and the importance of having the analysis, but he also talked -- and maybe he wasn't as clear as -- what I heard him say was the importance of data governance and data stewards because data, like everything, is subject to a lot of personal interpretation, and data can be used for good, and data can be used for not good, and we've certainly seen examples of some of that all around us in every part of our lives, beyond just healthcare. And so having that data governance structure set up in advance to prevent that

kind of unintended harm or even intentional harm -- and the stewardship is really, really important part of the responsibility of doing this. If it's something that Alaska is going to do, well then, what are they going to do with the information. Is it going to be used to provide a balanced perspective of where things are or is it going to be used for political purposes to demonstrate one end of the spectrum or the other? And we have to be really, really careful about that.

COMMISSIONER DAVIS: Thank you. We learned that it depends. It depends on a lot of things, and I said to Deb, it's kind of like the Affordable Care Act. You know, Speaker Pelosi said we have to pass this thing so we can open it up and see what's in it. You know, you had to pass the thing to write 10,000 pages of regulations to find out what it really meant.

So as we heard from Linda, it does depend -- and it struck me to know what it is requires a lot of up front definitions, such as what you just described, Val, you know, to say, is this something that the stakeholder groups would support or not support? Well, it depends on how that's built. So it's not just a matter of saying let's do this thing with four initials, but let's do this version of this thing or within these guidelines. So that's one point.

The second point is we heard from one important

stakeholder group, the hospitals, that they would like to have a significant role in figuring out, I think, what it would look like and what the rules of the road would be before they would decide to support or not support and that was very -- articulated well by Jeannie. Thanks.

COMMISSIONER ERICKSON: Allen and then Wes?

COMMISSIONER HIPPLER: I think he was before me, ma'am.

COMMISSIONER ERICKSON: Wes? Then Allen.

COMMISSIONER KELLER: It is kind of to that point, you know, it depends. I think what I learned today that I hadn't thought of before at all was the point that was made about it might take a statutory mandate to get past HIPAA and to get past the reluctance to divulge price information that is contractual and that really bothers me because it's a big it depends, you know. I mean, if this gets cut loose at that level, be careful what you wish for. And if we can find, you know, something that would incentivize transparency other than that, you know, let's really scratch our heads and think about it.

And maybe just for what it's worth, you know, I was thinking about the non-participating discharge database participants. Maybe we should get them in here and pick their brains a little bit and see. Maybe that would divulge something about the market that we don't know to negotiate.

COMMISSIONER ERICKSON: Allen and then Jeff?

COMMISSIONER HIPPLER: Thank you. I believe it was Ms. Brodie who was discussing that, in her review of some data, there was a link between behavioral health and emergency utilization; is that correct?

So first of all, that was interesting to me. Most you are in the medical fields, and maybe this is no surprise to you. It was to me. It just never occurred to me that there was that link. So the data mining can be useful. But then didn't she further go on to talk about assigning care managers to these people?

I guess, when the State is writing the checks, it doesn't really bother me if we have actuaries looking over their medical records and trying to figure out how to save expenses in the future. I guess I can deal with that. I don't like the constant violations of privacy. I really don't. It seems like we've gotten into a position where, because the state government is paying the bills, the state government has the authority to know everything about you, and the state government can decide that you would really be better served if you had this physician or that physician. I don't know how to put that in a sentence. It just -- I'm usually not one to complain about privacy, but there is a concern about violations of privacy when you collect data.

COMMISSIONER KELLER: On that point? I asked Linda, on the break, what other states did with that, and they said that

-- she said -- I don’t know if she said many, but at least some, opt to have opt-in/opt-out, if they go to mandatory so that the individual, you know, consumer can say yes or no as far as their own data is concerned, but this is a very -- I want to -- from my perspective, this is a very complex and very tough area, and I want to just tell you what happened.

Last year, we had a young man came down, and he wanted to be a CPA, and he wanted to -- they asked -- to take the test, they required biometric information, which is a fingerprint, and he said, I don’t want to give them my fingerprint. I want to use my passport. Well, you see, it’s a private entity that is requiring that, you know, so we have the decision then in government, okay, do we tell the private entity what they have to do or can’t do or shouldn’t do in this, you know.

And the reason I’m bringing that up and pointing it out is I was shocked at the level of feedback we got from a lot of different arenas. It’s a big issue when you start talking, you know, privacy and biometric information. You know, private information, there is money in it, which I don’t pretend to understand, you know. We have information here about the sale of data that -- what is it? H-Cup or whatever it is, you know, and I don’t know the dollars or anything of what’s involved, but I know that it is a market there, and the point Val makes is really not wasted on me. I mean, that is an issue that, you know, once we head down this road, we’re

going to have to look at it, but maybe not. HIPAA is something that kind of gets us off the hook, you know. I mean, we just point at HIPAA.

COMMISSIONER DAVIDSON: So I've said this before, and I'll say it again that HIPAA is as irritating and as helpful as it can be at times. I mean, it's there for very good reasons. I mean, I remember being a child and hearing on the radio, KYUK, at 4 o'clock everyday, will the following people please report to the V.D. clinic? You know, that would not happen today, and the reason it would not happen today is because of HIPAA and other kinds of things that -- I mean, American Indian and Alaska Native data and genetic information, all kinds of information that has been mined by the federal government for many, many years, all in the notion of, well, if we're paying for it, if we're providing something, we ought to be able to get something back in return. There is a whole -- I'm not going to go into the detail, but there is a whole litany of challenges that can happen if those kinds of things aren't considered very carefully.

So Allen, you actually have a really valid point, that we do have a tremendous responsibility when we're talking about people's personal information, and it only takes one slip for things to go really bad really quickly.

COMMISSIONER DAVIS: I should resist the temptation. So

I learned today that CPAs are ten times more trustworthy than insurance people because I didn't have to give one fingerprint; I had to give all ten, so.....

CHAIR HURLBURT: It made your day. You all thought it was (indiscernible - away from mic).

COMMISSIONER DAVIS: I did. You improved it significantly.

COMMISSIONER ERICKSON: Allen and then Keith?

COMMISSIONER HIPPLER: I have a clarification for one of Dr. Urata's earlier comments. You stated, sir, that transparency was linked to quality. I have no doubt that this would be the case, but do you have any data to support that? I believe it is the case. I would just like to see if there is any data to support that.

COMMISSIONER URATA: Well, you know, we have advertised core measures in our hospital on the Medicare website or Hospital Compare. So as soon as that started coming up, we looked at what was being measured, and our CEO got the doctors and nurses together and looked at our systems to make sure that we met, you know, grades that were competitive, or you know, good, you know, in the green. And so we found that, in our systems, to get the 100% compliance or 100% grade, we had to develop order sets and that's what we did, so that we standardized the treatment care to include things that were supposed to be done, like get -- you know, a person that comes

in with chest pains, you get an EKG within 30 minutes. And then if they are having a heart attack, then you are supposed to administer the clot buster within 45 minutes. And we had to streamline our pharmacy procedures in order to be able to meet that standard. And now even though we don't have very many heart attacks -- and we're pretty close to 100% each quarter in meeting those guidelines.

So if that were expanded to other things -- pneumonia is another thing that we do, and we're trying to, you know, look good on the website. And in surgery, they have what's called SCIP measures. That's a national thing. And so that's my example in real life, and I attribute that to putting it on the website.

COMMISSIONER HIPPLER: Thank you. Thank you, sir. I appreciate that. Do you think it's kind of like the -- it is called the APGAR test for pregnancy -- for delivering babies? Is it like that, where you just start measuring things, and all of a sudden, things start getting better?

COMMISSIONER URATA: The APGAR test is the condition of the baby at birth, not how you do things to treat somebody who comes in with chest pain. And then based on the APGAR or how the baby looks at one minute, then you start implementing resuscitation efforts if the APGAR score is bad. And then you repeat the APGAR score in five minutes, and hopefully, it's normal.

COMMISSIONER ERICKSON: Do you know the story behind the APGAR score though? And it's a great story, and I'm not going to remember the details, but it was -- do you know this story? It was a female physician, Virginia Apgar, who was one of the first women physicians, and she -- or first surgeons, but she wasn't accepted as a surgeon as a woman. So she was one of the first physicians trained as an anesthesiologist, and her experience was at being in the delivery room as the anesthesiologist seeing these babies come out blue and being set aside to die. And so she came up with this mechanism -- because she was watching all of these male physicians, who were very competitive with each other -- a way to measure the condition of the baby when it was first born, and it became a competition with these physicians that my babies -- I can improve their APGAR scores faster than yours, and all of a sudden, all of these babies that had been set aside to die in the past, with just a little bit of intervention right after they were born -- so to the point about transparency and quality or some sort of competition, I mean, that's what -- one of the, I think, findings about improvement of clinical quality around transparency is bringing some competition into it. It's not just, oh, they're seeing my stuff, so I better do better. It's I have an opportunity to improve, and I can work on that.

Now just one other thing related to Allen's question and

then to Jeff. In the additional handouts you received this morning in your packets, I had included an article that was just published a couple of days ago in the *Journal of Health Affairs*, in the March 2013 edition, titled "Publicly Reported Quality-of-Care Measures Influenced Wisconsin Physician Groups to Improve Performance." And it's a report on a study that looked specifically at this and found that the physician groups participating in this initiative improved their performance during the study period on several measures, breast cancer screening, cholesterol control, just a couple of examples. So there is a peer reviewed *Journal* article on a study just on this question. I think there is more and more of that you can look at.

COMMISSIONER DAVIS: Thank you. Well, to Dr. Urata's point, it's kind of axiomatic in management that, if you can't measure it, you can't manage it. And it's axiomatic in Lean methodology that, if don't develop standard work, you can't improve. So what you described was a standard to measure to and then standard work to improve it and that's just -- those really are great examples of how quality can be improved through transparency. Thank you.

COMMISSIONER ERICKSON: Jim?

COMMISSIONER PUCKETT: Well, something that I kind of concluded at work has been validated and confirmed for me today and that is, for the data, there's going to need to be

some serious training and education for the people that will be working with the data, and I don't remember who said it today. It was either the gentleman from B.C. or Mr. Hirst, but I wrote it down because it caught my ear. What is obvious to the person asking the question may not be obvious to the person pulling the data, analyzing the data, or interpreting the data. And I've already seen where I work, where we know we're going to have some people that have been trained for claims data analytics or data analysts, whatever you want to call them, and I'm sure the State doesn't have enough of those types of people. And I know the Health Care Commission has some other recommendations in regards to making sure there is plenty of professional medical people in the state, and they support that, and we're going to do the same with the people that would be looking at the data and working with the data that we want mine.

COMMISSIONER KELLER: On that point? One thing Linda talked about was the cost, you know. My first reaction when I saw $1.5 million up there, what a bargain. And even what Val said, I don't care if it's four times that, it's a bargain. Without -- but when you start adding what you're talking about and what has come out today so well, you know, is that data isn't the information. That's where the cost is, is the application, you know, but if we could get to the application for $1.5 million or six, you know, I'd say, it doesn't make

any difference. That'd be a good deal.

COMMISSIONER ERICKSON: And I'm just going to ask Linda for clarification on that point. My understanding was the cost estimates that you all provided Linda included the cost of analytics.

MS. GREEN: Deb, that's correct. We felt that that was an essential piece of developing any APCD I mean, yeah (affirmative), I can collect data and put it in shoe box, but you really have to use it.

COMMISSIONER ERICKSON: Wes, Jim, and Val?

COMMISSIONER KELLER: (Indiscernible - away from mic) because mine's probably the most valuable. I was going to just ask you to be sure you talked to the department that writes the fiscal notes before you (indiscernible - voice lowered).

COMMISSIONER PUCKETT: I remember that you shared the first year of costs, but was that annual cost? Could it be that much from now on?

MS. GREEN: The report breaks out start up costs and compares and then has annual cost thereafter.

COMMISSIONER DAVIDSON: So how many people and what kind of people are they?

MS. GREEN: The staffing for this varies because some states have internal capacity, and they don't need to higher people to do this full-time. They have in-house capacity.

That's the low end. The high end is hiring contractors to do the entire analysis, doing soup to nuts for you. So it isn't broken out into numbers of people. I've seen it -- I've run a shop that was very small that has since tripled in size as the APCD got underway. So we did it, at first, with about three people, and as they've realized what they wanted to do with the data, they needed to add more as time went on.

CHAIR HURLBURT: I agree that, in terms of the state paying $2.25 million of the State's aggregate healthcare costs of $8 billion, those costs are modest and less than a rounding error, but that's why I commented before. I was concerned that we hadn't really been able to see, with assurance, around the country that it has made a difference. And I think we have to accept that we will make mistakes in trying to address such a major societal and economic issue, but it's our job to try to be smart enough to figure out how to minimize the mistakes. So if there is a real bang for the bang, if there really is a product that makes a difference, then that's a pretty modest cost. If it's not really making a difference, then $1.0 dollars or $1.5 million is a lot of money. So I don't know.

MS. GREEN: The question that I'm hearing is, do we have to be getting a return on investment in a straightforward way? And I'd answer that by saying that we'd want -- we'd see building a database that could serve as the foundation for

diverse reports, diverse analysis, try not to aim for one particular product, but try to diversify. And when there is data, they will come. People -- and do these organizations know the value of this information and when it's out there, when it's shown to be reliable, as an APCD does need to do over its first years, then it becomes a resource for everyone. It's not a one-step process. It does take multiple steps to get there. I think that there are opportunities to think about ways to do it an inexpensively as possible. There are bells and whistles that may not be needed right away. The New Hampshire website, for example, is very bare bones. The Massachusetts website has somewhat more bells and whistles and was, consequently, more expensive. The Colorado website has some bells and whistles, the mapping and the color shading. That's more expensive. That might not be what you need right away.

COMMISSIONER ERICKSON: Can I put you both on the spot, potentially, for a second? Ward and I had an demonstration of a system that was -- essentially, it was a health analytics tool, wasn't it, where, if we provided the data -- and I'll mention the vendor; we get contacted by vendors all the time and usually ignore them, but this had made its way through a number of routes and landed in our lap. So we participated in a demonstration, and it Truven Analytics. It was formerly Thomson Reuters, and they've developed this analytic tool

which, to my very lay perspective, was -- would do a lot of the work, and I don't know how much it costs, but I think that's what you were referring to is that there are already these tools out there, if we could put our data into it that had been through the ringer several times, and it's being used.

Now to Mike's point earlier, too, as I was sitting through this demonstration, Dr. Hurlburt was asking the demonstrator lots of questions, and I kept thinking this is really cool. I have no idea what they're talking about. And so we're looking at all of it, trying to understand the clinical issues, and Dr. Hurlburt, with his expertise in medical management, knew the right questions to ask and that was my -- my second thought was, if you don't have the right person sitting in that seat asking the right questions, still, having this cool tool will be useless. But I don't know, you know, if -- I guess part of my point is these tools are being developed now and are -- you're increasingly able to just kind of buy them off the shelf.

Commissioner Streur, this morning, mentioned, meanwhile, it took us ten years to get MMIS up and running, the new Medicaid Management Information System, to the point where we're going to be operational, I'm confident now, this fall. Everything they're testing is working. The eligibility information system they are, essentially, buying off the

shelf, and it's going to be operational, the first phase, in just a few months. And so I don't know if either of you would comment on if I was understanding that tool correctly, Ward, and if you think that's what you were referring to, Linda, when you were talking about the contracting that we could do, though we might not be able to develop that type of expertise and develop systems from scratch in-house.

CHAIR HURLBURT: Well, let me go first and then you because you'll have a more global perspective, but I was impressed with their presentation that they had, and it sounded like a good product, but one of the reasons I'm also impressed with the response that we really have seen the benefit, and you know, I agree that you need to have medical management ability, which doesn't just mean physicians, but people who understand that this is Alaska, and as the only state that has never, ever had an HMO, that will die before we'll let one in or whatever, that one of the side effects of that is probably we have as little medical management capability in this state, probably less than anybody in the country, less than territories with less population than we have, because we've never lived in that world, really.

Now, there is no unmanaged product. There is no such thing as just pure indemnity insurance. It's all managed indemnity. So there is some medical management that goes on, but we really don't have a whole lot of medical management.

Jeff, you should disagree because you walk it, day-by-day, more than I do, but at least, I am impressed we don't have a whole lot of medical management capability in the state. Linda?

MS. GREEN: So Dr. Hurlburt, I'm not sure I got the question here.

CHAIR HURLBURT: I think Deb was making the point that you can get this data and you can get this information, but that, if you don't have the ability to use it, then it doesn't benefit you, so that a corollary to obtaining the data and obtaining the information is having those who understand the implications of it can help advise others and can help use it profitably and saying that's an important part, and I was saying that's part of my concern because I think, of all 50 states, we have the least capability in what other states would call medical management probably because we've never an HMO in this state.

COMMISSIONER ERICKSON: Well, and I think the clarification, too, that I was looking for is that, if you -- are you familiar with that Truven solution, and is that sort of system that you based your cost estimates on for the analytic piece, if it was going to be contracted out?

MS. GREEN: Thank you. The -- yes. That is the kind of analytic tool set that could be created with APCD data. There is the front end piece, and there is some oversight in

management as well that doesn't run by -- contractors, as you know, don't do what they are going to do without some insight and supervision from the contracting authority, but yes; those are the kinds of tools that could be overlaid onto the collected information.

COMMISSIONER CAMPBELL: I've been sitting here listening and thinking about this morning. I guess I'll ask a contrarian question. Are there other ways to go about this to get most of everything that we think we want at this point in time, without going to the full-blown creature we're talking about right now? Are there some add-ons that you could do and get most of the information? You'd have to negotiate, if you want the full-blown APCD (indiscernible - voice lowered) to negotiate with VA, with tribal health, things of that nature. If we went ahead and did that and got that information into some sort of beast that we have designed or into the hospital database and could extrapolate data from that or is it just easier to go ahead and spend the money to go ahead, as we're talking about this morning? It takes more management, I suspect. I didn't say it very well.

COMMISSIONER ERICKSON: Are you talking about whether there should be a voluntary system as opposed a mandatory system?

COMMISSIONER CAMPBELL: Well, we know that the voluntary doesn't work very well. We've been talking about those

exceptions all day long, and the (indiscernible - voice lowered). And obviously, it's going to take legislation to get the VA to sit around the table and tribal health and things like that. So you know, it would have to be mandatory, but I'm just wondering if you need the full-blown data set or whatever we described as the entity -- as I guess the question is, in your other states, are they all basically getting the same data sets?

MS. GREEN: Some states don't have the third-party. States that I'm working with don't have federal employees or TRICARE. They have commercial. They have Medicaid. Getting Medicare. They're getting -- some states are getting the third-party. One of the states is getting -- two of the states are getting state employees. So the answer, narrowly, is no. They're not all getting the same data to the same degree of completeness that you might see here.

I will say that not all of them began at those levels, that some of the data came in, but they started their databases with the commercially insured. They expanded to third-party. They negotiated their agreements with Medicaid and got that data in. They negotiated their agreements with Medicare and got that in. Colorado, yesterday, passed legislation that allows the small group plans to report in. There had been an old provision in the law that prevented them, and they got that passed yesterday, but they're well

underway. They have over two million lives in their database already. So you know, could this also be a gradual building process? Something -- the end point, the goal is to have everything, everyone. Maybe we start with something that is within grasp.

COMMISSIONER ERICKSON: Allen?

COMMISSIONER HIPPLER: So it seems -- I could be wrong here, but it seems like we have two separate potential users of the claims database, and one would be a hypothetical consumer who is price-sensitive, who is looking for medical care, but it seems like the other one would be the State of Alaska that's going to manage not so much its retirement system liabilities, but specifically, it's Medicaid liabilities. And I'm wondering how the State of Alaska would -- once the State of Alaska knows, for example, that a certain hospital or medical care provider in a community is cheaper than another one, what would it do with that information? How would it benefit from it?

COMMISSIONER DAVIDSON: They already know that. The Medicaid data system provides information, provides claim information to the State, and the state insurance system, as a payer, also gets that information. So they have it. But the other -- I just wanted -- there were a couple of comments made earlier about the federal -- compelling the federal system, whether it's a VA, whether it's TRICARE, or whether it's

tribal health, to do that by law, and I just want to make sure that everybody understands that the only way to do that is to compel them by federal law because they are subject to federal law, not state law.

COMMISSIONER HIPPLER: We'd have to be pioneers.

COMMISSIONER ERICKSON: I was going to respond to Allen's question some more, too, but do you.....

CHAIR HURLBURT: Well, just maybe to Val to think that's not clearly true, but I think that, when I picked up the point when Linda mentioned that, at least from my experience living in a number of areas, the collaboration among the various sectors here -- you know, while it's not always totally collegial, it's generally very collaborative, and if there is value in getting all of these various entities in the field to work together, probably the chances of pulling that off here are better than anywhere because my bias is folks of Alaska really work well together. So to get the VA, the military, tribal health system, the State, the private sector, if you can really sell the vision, I don't think we have as high a wall to climb to get folks to do it, but obviously, the State cannot compel the Feds or the tribal health system to do that.

COMMISSIONER ERICKSON: Keith, to that point? I still want to respond to Allen's question some more, too, but.....

COMMISSIONER CAMPBELL: Well, that just leads me -- the Doctor's comments lead you to the suggestion that ASHNHA made

about a stakeholder's group, if you're going to do something like that, sit down around a table and try to iron out something like that.

COMMISSIONER ERICKSON: I think we might be segueing into Findings and so I'm going to capture that point. But back to Allen's question, I didn't want to leave that hanging. To the State's use, we did hear from Dr. Fenaughty about the public health uses and the gap in data regarding the burden of morbidity, illness burden in the state. While we have good data on death and some basic vital records and survey data, that that would be another use that the State would have.

But back to -- and something we haven't talked much about today, but the use of this data for supporting payment reform and the reason why, I'm sure, the federal government made, as an allowable cost for those State Innovation Grants that were just awarded, development of All-Payer Claims Databases in those states, and specifically to support multi-payer payment reform initiatives. So at some point, should the State Medicaid Program and the State Employee Health Plans decide to collaborate with other private payers, like Premera Blue Cross Blue Shield, to do some demonstration projects around new payment models, bundled payments, those sorts of things, that this would be one data source that could be used to support the modeling and to help calculate risks around -- financial risk of the different parties involved, working with the

providers. So that would be a use, while it wouldn't speak -- while it might not help them manage, specifically, just the Medicaid population and utilization and costs because, as Val said, they already have that data. That would be a more robust data set for doing broader collaboration with other payers. Val?

COMMISSIONER DAVIDSON: So did the State of Alaska apply for one of those Innovation Grants?

COMMISSIONER ERICKSON: The State of Alaska did not apply for that, one of those, and I don't know if it was because we didn't feel we're quite ready yet because of MMIS. I have heard that there hasn't been active moment towards working on bundled payment demonstrations because the old COBAL (ph) system where the MMIS data is held in now, it just makes it too hard to plan for something like that, but that the new data system and the new MMIS warehouse will enable that. Allen? And then let's see if we can capture some Findings in the last few minutes in the day, spots about Findings.

COMMISSIONER HIPPLER: Well, I hesitate to say this because it might sound a little argumentative, but just for the sake of shocking people, I'll just throw it out there. If, really, the only immediate potential user is the consumer, the private insured who is price-sensitive, why don't we just hire Mr. Dave Hanson, who was here earlier today, and just have him call a bunch of people and find the prices for 30 or

40 elective procedures and post that on a website?

COMMISSIONER ERICKSON: So is that your first suggestion for a recommendation, Allen?

COMMISSIONER HIPPLER: I put it out there to get a reaction. The reason I did that is so that I can get a response and better understand the use, the perceived of the All-Payer Claims Database.

CHAIR HURLBURT: Wes?

COMMISSIONER KELLER: Aren't you going to put that one up there? If you do, put HSA after it.

(Pause - background discussion)

COMMISSIONER ERICKSON: What, specifically, about HSAs?

COMMISSIONER KELLER: Well, just that I see HSAs doing exactly that. If I've got $5,000 in my account and I'm needing to get a procedure done, I'm going to do some shopping, you know, and maybe I'm the only one, but I think everybody is there, you know. I mean, it's an old argument. I don't -- sometimes, you bring these words up that we hear so many times, and they bring a negative response. I don't mean to do that, but nonetheless, I think it's a (indiscernible - voice lowered).

COMMISSIONER ERICKSON: Can I ask another question or two to this point? I'm just thinking about the -- we estimate there are -- 18% of the Alaska population is uninsured, and if we assume that tribal health system beneficiaries have some

level of financial access to care and back them out, then it's 14%. But what about the 14% who have no insurance, do they need price transparency? So anyway, that was a rhetorical question.

COMMISSIONER MORGAN: I was running on the assumption that, listening to Commissioner Hultberg, the Commissioner of Administration, (indiscernible - voice lowered), besides her $500 million of services she is purchasing or paying for, listening to her, that one of her main issues is she has no price transparency. So she can do work to (indiscernible - background noise) special programs or incentive programs or to direct retirees or state employees to purchase stuff. I know -- I don't speak nor represent tribes, but I know they do buy some healthcare services outside of their system, contract health. You have, besides individuals (indiscernible - voice lowered), but this Insurance Exchange where the people will better offer insurance in the Exchange, and I would suspect a lot of these uninsured people, as long as they were between 100% and 400% of the poverty line and they're not tribal, will be required to buy insurance, but they get a subsidy and a slide. So there will be programs there.

I would suspect that there -- as we go through this evolution, that the individuals that are either buying it or doing actuarial work to set up programs to pay for it would utilize this information or have I have missed something in

all this, that we're just -- you know, that -- you know, I mean, I don't -- from the literature, it looks like everyone is planning to do something, to review what they're paying for, to review what the quality is, what are the results, and it would seem like you would need something to go into and look to get some of that information.

Now Blue Cross Blue Shield, evidently, has a very sophisticated current system for the things that they're paying for, but will there be an evolution or look at doing it in other ways or purchasing it from other providers? I don't know. Only Jeff Davis can mention that. But I can tell you the Commissioner of Administrator, I've sat in two of her presentations and watched the one either in front of HES or Finance -- I can't remember.

UNIDENTIFIED FEMALE: State Affairs.

COMMISSIONER MORGAN: State Affairs -- was talking like this, that she needed transparency and needed this type of information to give her some planning management room to do some stuff. You know, she didn't get into a lot of detail because, evidently, we're falling into contracts here or something, but if she had that information, she might be able to do some stuff with contracts. Now, I may be extrapolating something. As someone that's been misquoted in some newsletters myself in the last weeks, it would seem like I may be doing that or doing her an injustice, too, but I think she

is, but -- so I mean, all that, aren't they going to -- somebody going to be wanting to get this information or have we wasted, you know, this whole process?

COMMISSIONER ERICKSON: Was that a question for Jim? And then Bob and Val had their hands up and Jeff.

COMMISSIONER MORGAN: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Did you want to answer Dave's question?

COMMISSIONER URATA: Me? No. I just had a comment, and I agree with your question, but I thought that Commissioner Hultberg did what I now term "a Dave Hanson" and discovered the cost of colonoscopies and compared them to other places, like Seattle, and realized that she could save money by buying a plane ticket and so that's what I thought her point was, when she spoke to us a few meetings ago.

COMMISSIONER MORGAN: Yeah (affirmative), but what got, in another meeting, was that's what she -- she could tell you what she's paying for colonoscopies, and she can find out, like our gentleman in the back of the room, by picking the phone and calling or her third-party administer did -- what they are in Seattle -- but she couldn't tell you everybody that provides colonoscopies in Alaska and what would it cost (indiscernible - voice lowered) or what she'd be charged. Do you see what I'm getting at? She could tell you -- she could find out in Seattle. She could tell you, like Jeff can for

Blue Cross, but I'm suspecting that there is -- that, when I heard her in a later presentation, there might be other people providing colonoscopies in the state of Alaska, and she has nothing to look to find out what you have to pay or what they charge, or if we call had this information, maybe an entrepreneur might come up here and we have competition, but it's all speculation.

COMMISSIONER CAMPBELL: Well, I hope he's a doctor.

COMMISSIONER MORGAN: I hope he's a doctor, but not necessarily with a Russian accent, I guess, is what.....

COMMISSIONER DAVIDSON: So since you brought up exchanges, I mean, there is going to be a requirement for people to have some kind of coverage, whether it's Medicaid, whether it's Medicare, whether it's private insurance, or whether it's through purchasing of an exchange.

The interesting thing is that the Affordable Care Act actually closed one donut hole in Medicare Part D, but it unintentionally created another one when the Supreme Court made the decision that Medicaid expansion is going to be optional, not mandatory, and the interesting thing is, in our state and in every other state, for a state that chooses not to do Medicaid expansion, individuals who are less than 100% of the federal poverty level are not going to be eligible to participate in the Exchange. And we have people in Alaska who are at less than 100% of the federal poverty level who will

not be eligible for Medicaid under our current Medicaid program and are not going to be eligible to purchase insurance under the Exchange, so they will be subject to a $695 penalty.

COMMISSIONER MORGAN: I think they can buy insurance in the Exchange. They do not get the subsidy or the credits, but that could be changed by a simple change in regulation by the Secretary of HHS, just simply by promulgating the reg, which she has that authority. So there are about 11 states -- or there are nine states or whatever it is that that will need to be addressed, and I digress here, but the point is -- I think the point is that I can't believe, after all this and listening to all of the people that are going to use data to do stuff, to manage this care and to come up with options for purchasing, that, you know, I guess I'm reaching for it, too. They've got to have someplace to go get this information, somehow, and the colonoscopies was the best one I could come up with. Like you said, she suddenly found out -- she knew what she was paying, and her third-party administrator or somebody called Seattle or maybe someone in Seattle called her and said, hey, we can do them for "X" and it was the travel and the colonoscopy and all of it was cheaper than getting it here, but she told me, two Saturdays ago, she really could -- that's all she knew. She didn't know about whether or not there were other people who provided them in the state of Alaska and what would they cost her or what they charged her

and that's a third part of the stool that you would get from this type of information. Maybe. I guess. Is that close?

COMMISSIONER ERICKSON: I feel like, just, I need to be fair and let Val respond to your comment and then we can get back on and stay on the transparency conversation.

COMMISSIONER DAVIDSON: It is a part of transparency, and a part of that transparency is representing facts, actually, I mean, truly. How many people do you know, that are at less than 100% of the federal poverty level, who are going to be able to purchase private insurance without any support or any help whatsoever? None, especially after we heard Jeff say earlier, we expect, for everybody, the cost of premiums to rise by, what, 20% or so. So if we thought they were unaffordable before, guess what they're going to be now? So let's be real, as long as we're talking about transparency. People who are at incomes of less than 100% of the federal poverty level aren't going to be able to afford health insurance. They're just not, so they're going to be cut out, and they're going to have to pay a $695 penalty on their taxes.

COMMISSIONER KELLER: Consider ourselves a (indiscernible - away from mic).

COMMISSIONER ERICKSON: So to the transparency question again, we don't have -- beyond hiring Dave, and we have no idea how much he'd charge. You might charge us way more than

All-Payer Claims Database to call every provider and find and publish their -- do we have anything, besides if we're going to plan an All-Payer Claims Database, that stakeholders would need to be involved? Do you want to -- let's -- I think I need to go to being a little more directive on our recommendations. Let's focus on All-Payer Claims Database and then talk about Hospital Discharge Data and then other transparency legislation mandates for providers to make their information transparent. Can we do that, real quickly? And then we'll continue this conversation first thing in the morning. Yes, Jeff?

COMMISSIONER DAVIS: Well, I don't know how helpful this is, but I don't have -- I can't give you a recommendation because I'm at, at least, two minds about this, if not three minds about this. Let me explain what that means. I believe what I said earlier. If you can't measure it, you can't manage it. So you've got to have some sort of data. I know, from our own experience, that we've spent years building the database, and it took a while before the utility really took off and you built the expertise to do it.

Thinking about Wes' comment about, you know, a $1.5 million/$4.5 million against $2.6 billion in expenditures or $8 billion in the State, you know, that might be a bet we're willing to take, even though we can't really see the end point because there is such a small piece of something that's

growing so fast.

So these are kind random thoughts, but hopefully, they do link together. If you're Jim with spending $500 million or Premera $500 million, you have enough data, if you want to spend the time, you can develop, you know, some price transparency of your own, but that's -- what about the rest of the population? So I almost get to the point of saying, it's probably worth the bet. It's probably worth putting the money out there, kind of as a little bit of a leap of faith to say, if we don't do it, then there is no chance of developing the means to manage this beast. If we do do it, at least, we're taking some steps down that road.

Now if we do it, we have to define what "it" is, and we have to do it carefully and all of those things, but it almost feels like to not develop the means to measure and manage both cost, and potentially, quality -- and I'm thinking of Dr. Urata's examples; those are pretty powerful examples -- if we don't take that bet, we almost lock ourselves into the current state, and we never make much progress towards the goals of this Commission. So again, it's not a recommendation, but it's kind of where I am, and maybe, by the morning, I'll have more clarity.

COMMISSIONER ERICKSON: Jim?

COMMISSIONER PUCKETT: Well, I certainly don't want to speak, you know, for my Commissioner. She can certainly do a

good enough job of that herself. But if I read her right in all the conversations that I've had with her about transparency, she wants the transparency because it's good for everybody, and she's using her own personal experiences to describe why she thinks that we need the transparency. As an individual consumer, she saw.

As a very, very informed consumer, she was able to get the information that the average layperson would not even know how to get the information. And so she does want the transparency, but it's not just for her, specifically, as the Administrator of a health plan, although that would certain help us to manage it better. She is asking about it because she just believes that every person in Alaska should be able to get the information they need to make an informed choice for that type of service.

And you know, I don't think we can draw the same parallel with someone shopping for an automobile as you can for medical care, but I think all of us can agree that people in the State do need easier access and more information for -- especially for elective services. They should be able to a comparison. Right now, it's extremely difficult. And I'm an informed consumer, and even in my own family, we found it very difficult to get prices and to a little bit of comparison. So I agree with the Commissioner on that point. Transparency is essential, so that people of Alaska could become informed

consumers of their healthcare, and I think that's really what she's getting at.

COMMISSIONER ERICKSON: Yes, Larry?

COMMISSIONER STINSON: We're still talking about healthcare by the way the current situation is. In three, four or five years, it could be very, very different, and I think, without question, it's going to be putting more of the expense and the risk on the individual patient, and I think that this is a good bet for the future, if, for no other reason, based on that, because that is where healthcare is going. Even though market forces may make it a wash right now, I believe that, in the future, this is going to become more important when people are risking their own funds on a greater basis for their healthcare.

COMMISSIONER ERICKSON: Yes, Val?

COMMISSIONER DAVIDSON: So I was just wondering about next steps?

COMMISSIONER ERICKSON: So what -- we are going to continue this conversation tomorrow morning. We have another hour on our agenda, and maybe folks will feel a little more fresh. And I'll take these bullet points and clean them up a little bit and give them to you, in a handout, in the morning when we start, and we can continue the conversation. So Mr. Chair, if we can recess until tomorrow morning at -- we'll start at 8 o'clock sharp. If you could be here at 7:30-ish,

that would be great. Thank you.

4:29:42

(Off record)

SESSION RECESSED