ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

8:00:58

(On record)

CHAIR HURLBURT: Could we go ahead and get started and get everybody around the table? I think we have a quorum and almost everybody here.

COMMISSIONER BRANCO: Ward, this is Pat Branco. I'll be able to join the call here for about an hour.

CHAIR HURLBURT: Today, we want to start out this morning and kind of wrap up on some of our discussions from yesterday, have, basically, a first hearing on some by-laws change, just to make sure we're consistent with the legislation that established the Commission, and then we're going to focus, really for the first time, in looking at oral health, which is a significant health component and significant issue, particularly for us here in Alaska. And then we'll finish up by looking at some of our prior year recommendations, looking at the Healthy Alaskans 2020 project, and our regular update on ACA issues. So Deb, I'll turn it over to you.

COMMISSIONER ERICKSON: I wonder if we can -- thank you. We are official. Would it be all right with all of you if we flipped the first two things on the agenda and just start with Ward having a brief conversation with you about the -- with Ward chairing and just seeing if you have any questions on the by-laws change while I reboot the computer and deal with a

technical problem? Well, it's important. Procedural issues are important. Does anybody have any concerns with moving the by-laws change discussion up now? Okay. Ward, would you mind just kind of facilitating a conversation to see if anybody has any questions, if I start off with a brief explanation?

One of the benefits of having an audit -- I mentioned to all of you in an email not too long ago that Legislative Audit has begun the sunset audit, which is a typical procedure for any body that has a sunset date, that 18 months in advance of the sunset date, an audit process will begin, and they do look at all of our procedures and activities and make sure that we're following the rules, that we have rules and that we're following them, but they also will look at whether the Commission is serving both their intended purpose and serving a public good and will make a recommendation to the Legislature to those points.

So one of the benefits is, you know, they're already highlighting some areas where we can improve procedurally and pointed out that our by-laws that we had established before the Commission was established in statute -- we had scrambled right after we were established in statute with the group expanding to change the number required for a quorum, but we hadn't updated other parts of the by-laws to be in conformance with our statute.

And so what the proposed change does -- and you have it

behind tab one in your notebook, right behind your agenda -- is bring both the description of the members, the membership and the description of the duties to match exactly what's in the statute, and I provided a copy of the statute behind the proposed by-laws change so you can check and see if you have any questions.

Under our by-laws, we can't make changes to the by-laws at the meeting at which they're first proposed and so you all received them over, I think -- the changes over email at one point, but we won't consider until maybe reading it the first day of next meeting in June and then vote the second day.

So with that, if you all have any questions or discussions about it, I need to reboot the laptop, and maybe Ward could handle those. Is that okay?

COMMISSIONER URATA: Do you need an action today, like a motion, or is it just information-only first reading, and then subsequently next meeting, we'll have the action?

CHAIR HURLBURT: Yes. Yeah (affirmative). Are there any questions or comments or suggestions? I have one tiny one, and this is to take out a period, but it does make a difference. The legislation is what I believe is appropriate on this. It's page three, paragraph eight. Or it's not a period; it's a comma. Page three, paragraph eight where is says -- between "primary care" and "internal medicine," there is a comma, and there should not be, and the legislation does

not have it there. It's -- the intent was to be, in talking about who is going to be a primary care doc, it's not any internist. It's not a hematologist or a hospitalist or something. It's a primary care internal medicine doc.

COMMISSIONER ERICKSON: Good catch. I think Leg Audit should hire you after you're done with this stint.

CHAIR HURLBURT: Maybe nobody else would talk to me.

COMMISSIONER ERICKSON: I'll make that correction. That's actually really important. Thank you.

COMMISSIONER DAVIS: Highlighted items are the changes?

COMMISSIONER ERICKSON: Yes. More explanation about the changes before you, I've highlighted in yellow any place where there is a change, underlined additions/added language, and struck through deleted language.

(Pause)

CHAIR HURLBURT: We will bring it up again when we vote on it in June, but I believe that Deb did a very thorough job of making sure it's consistent with the legislation.

COMMISSIONER ERICKSON: So if we're ready to move on, you all have, in front of you now, a five-page document, and for folks in the room, it is available on the back of the table, and I apologize to folks online. We're not able to update our website very quickly, so I'm not able to provide it on the Web at this point, but will in the future.

The last two pages -- I'll point, first, to the last two

pages. The last two pages of this document, pages four and five, are the notes just as I captured them on the slides yesterday. So you can refer back to those bullet points that were up on the screen while you were talking. What I did on these first three pages then was try to pull out some common themes and organize them around early preliminary draft Findings and Recommendations related to transparency, All-Payer Claims Database, and Hospital Discharge Data.

So if you want to take a couple minutes, while I continue to work on the laptop, to review this and then we will just continue the conversation from yesterday afternoon and continue improving these and adding to them. And it occurred to me, at the last minute -- I wish it had occurred to me a little bit earlier, but if you think it's important, I brought the document down. I kind of -- I hate to recreate the wheel, and we do have Findings and Recommendations already related to transparency and the Hospital Discharge Database and All-Payer Claims Database in a previous annual report, and you do have the Recommendations in the other document that I was referring yesterday, this Core Strategies and Recommendations. What's not there are our previously approved Findings Statements, and it might have been helpful to you to have those in front of you, too, and if you think it's really important, I could actually probably pull them up on the screen. But anyway, if any of you have questions or comments -- I want to hold off on

the brainstorming for just a couple minutes while the computer reboots, but if you have questions or comments about this document that you want to raise at this point, feel free to do that.

CHAIR HURLBURT: Why don't we just take the time to look through it quickly while the computer is rebooting?

COMMISSIONER BRANCO: Ward, if you don't mind -- this is Pat Branco, and while I won't have an opportunity to review the notes from yesterday and I'm only able to participate for a little bit this morning, I would like the opportunity to review the notes and make comments on them as well.

COMMISSIONER ERICKSON: Pat, do you have access to your email? Pat, did you hear me? This is Deb.

COMMISSIONER BRANCO: Sorry. I was on mute. Yes. I do.

COMMISSIONER ERICKSON: Let me see if I can email it to you quickly.

COMMISSIONER BRANCO: Terrific. Thank you.

(Pause - Commissioners review By-Laws)

COMMISSIONER ERICKSON: Pat, the email was just sent. So hopefully, it will show up in your inbox soon.

COMMISSIONER BRANCO: Thank you very much. I've got it.

COMMISSIONER ERICKSON: Technology can be wonderful, at times.

(Pause - Commissioners review By-Laws)

COMMISSIONER ERICKSON: Barb is going to make a quick

copy of the page from our 2011 report that has the Findings related to transparency. So we'll have those in a second, too.

(Pause - Commissioners review By-Laws)

COMMISSIONER ERICKSON: I think I'm ready, if you all are. So I have suggested, again, breaking up the transparency Findings and Recommendations, at least for now for purposes of conversation, from Findings and Recommendations related specifically related to an All-Payer Claims Database and specifically to a Hospital Discharge Database. So does that work okay for all of you, and should we start with a conversation just about public transparency, price and quality information?

So what I had gleaned from the conversation yesterday and the bullets that we'd captured on the slides for the first brainstorming sessions was a general finding that consumers desire price and quality transparency and then some more specifics related to that, that there is some early evidence that consumers in the other states where that data might be -- that information might be more transparent do not utilize it fully, at least, due to, in part, lack of price sensitivity and perhaps, in part, due to lack of knowledge.

The point was made -- actually, it was by Emily, and she apologized. She had a work crisis this morning, but she anticipates being here soon. But Emily had raised the point

about the choice depends on the context of care, and especially in an urgent or emergent situation, price might not matter quite as much, price choice anyway.

Another point that was made is the healthcare system, it does appear to be moving towards greater price sensitivity for the patient that -- it's moving towards patient engagement in bearing costs and financial risk.

Also, the point was made that transparency could help improve clinical quality of care and also that one method of providing transparency is through public reporting of All-Payer Claims data. Another method is mandating providers to make their prices publicly available and that those two methods are not necessarily mutually exclusive.

I thought I would share, too -- while you are looking at that, I received an email last night that I thought I'd read to you and then there was some subsequent information from this person. So it's short. I'll read it to you and then I'll pass out the longer response that my response to her prompted.

So this was just a member of the public who was listening to our conversation yesterday. "Hi, Ms. Erickson. I wonder if it is possible to get the name and/or contact information of the individual who spoke during the public comment opportunity. I'm specifically interested in getting the name and a contact for the gentleman who spoke on provider price

transparency, the ability to know what something costs prior and during healthcare service delivery. This is of personal interest to me as well. My daughter actually had her healthcare appointment canceled, and the provider refused to see her when she asked for information regarding routine charges for services. I wanted to see if he -- that would be Dave -- could share his research with me. And if you're uncomfortable sharing his information with me, perhaps you could share mine with him."

And so I forwarded her email to him and let her know. And then she responded that -- in full disclosure, she said -- I asked if I could share her message with you, and she said certainly, and in full disclosure, that she's a Contract Officer for a PPO, but she's had increasing personal experience with her own family as well. So that's the disclosure part, but since it was along the lines and recent (indiscernible - mic cut out) to our conversation yesterday, I thought I would share this email with you as additional public comment on this point, as you're considering it this morning.

CHAIR HURLBURT: Any comments or questions on the Findings part there on transparency that Deb went through? I'll start off.

On the first line there, I think many consumers' duties are price and quality transparency, but I wonder, is it really broader than that? It's payers. It's consumers as payers.

It’s employers as payers. It’s insurers as payers. So I would wonder whether we should consider having it be payers?

And then on the third bullet down, the second indented bullet down, I certainly would agree with what Emily said about urgent and emergent situations. Then when you have a nurse call line, one of the most important things, functions they can do is, when the situation is right, to say hang up and call 911 right now. Don’t worry about where you’re going. Don’t worry about what the costs are. Hang up and call 911.

However, payers really are interested, and there can be steerage with educated consumers. And if you get a better rate, such as the State has right now at Regional, you would like your employees to go to Regional, if that’s where you have a contract. Or if there is an understanding and the word “urgent” is there, that there is a difference between urgent care and ER care, and you may be able to go to urgent care and have the same problem cared for, for a few hundred dollars that might cost you a few thousands dollars in an ER. So it’s -- I absolutely agree with Emily’s observation that, when you’ve got an emergency, the last thing you’re going to want people to worry about is what the cost is, what the contract is, and that’s what a call nurse will say, hang up, call 911, get taken care of. But there are parameters around that with being knowledgeable cost, so that you go where there may be a more favorable contract or to have the judgment to go to the

appropriate level of care when that's urgent care versus ER care.

COMMISSIONER BRANCO: Ward, this is Pat. Do you mind if I weigh in for a moment?

CHAIR HURLBURT: We would appreciate it, Pat. Thank you.

COMMISSIONER BRANCO: Certainly. This is one area that, you know, providers have been conflicted about over a period of time, and the perception is that we're resistant to telling anybody the prices. That's contrary to the truth. What we deal with is not getting put in the position of making a false estimate. On the outset of a course of treatment, it is unknown what the (indiscernible - phone interference) price will be. It is typically -- and as the physicians in the room will attest, the level of care evolves as the more information is learned about the patient, the needs, the diagnostic studies required. So one of the typical response that will lead in towards these is being able, with some certainty, to offer patients a range of prices, that it may fall within this category based on what we're hearing on the onset of the chief complaints. And so I think our language needs to be careful that we don't make a promise that every thing in a patient encounter we will have a price that's absolute and available ahead of the care or treatment or even the assessment and evaluation. I think that's a careful point that we want to make sure we don't overcommit to transparency, but the genuine

belief in trying to afford people the opportunity to understand what they're going to be charged, including payers as well.

CHAIR HURLBURT: Thank you, Pat. Other comments?

COMMISSIONER DAVIS: Thank you. I don't really think it came out yesterday, but in my discussions with physicians, particularly primary care physicians and others, they are also very interested in what things cost. I'd be interested in your comments on this, Dr. Stinson, but you know, we know that there is significant variation for the same thing, and Pat's right. An episode of care is tricky, but you know, a facility fee for a procedure is a comparable apples-to-apples, and when you know that, one place, it's four times more than another, then you make decisions based on that, if you're the referring physician. If you don't know that, you can't factor that in, and you know, it's been identified by the AMA and others that cost, prices are also a form of waste in healthcare that needs to be driven out. So it's not -- transparency is very tricky, but there are instances where it's important, and I think what I'm trying to say is that physicians who are helping make decisions with their patients are also interested in this and do not have access to it at this point in time.

COMMISSIONER ERICKSON: Yes, Jim?

COMMISSIONER PUCKETT: I don't think that it's asking too much of the industry to be able to provide a consumer a close

estimate of what something is going to cost. I know, as a consumer, I understood perfectly well when my bicep tendon was separated and I asked my physician what are we looking at here for costs, and he gave me an estimate, which, by the way, turned out to be pretty close. And so I don't think we're expecting the providers and the industry to tell us that this procedure is going to cost this many dollars, this many cents when a consumer is wanting to just see what are facing as far as expenses once my insurance pays for it or whatever. So I think we can work toward, at least, being able to do that where a consumer can have a pretty close idea of what they're facing before they make their decision on whether to go forward with treatment.

COMMISSIONER STINSON: Along all of those lines, everybody I know -- Ward, you know this, too. Sometimes, you go in for an appendectomy, and it turns out to be an adenocarcinoma, and you have to dissect lymph nodes. It turns into a big case. Someone has to be admitted to the hospital for a while. But still, if you took the median, maybe plus or minus the standard deviation, at least 80% to 90% of the time, an appendectomy is an appendectomy. A hernia operation is a hernia operation. So while there are always variables and things can always can get out of hand in specific instances, I don't think it is unreasonable to try to hit a fairly good median, and maybe with an asterisk saying, provided this is

all that is done, I mean, if you want to watch out for the legalities of that, and I think that that would be reasonable actually because, once you go in, you don't know 100% for sure, ever, what you're going to find. But still, I think, as a starting point for information, negotiations, patient education, it would be very reasonable.

COMMISSIONER URATA: So our clinic does OB in Juneau, and we always have, on a piece of paper, global fees for routine OB care and what's expected, and you know, a range payment and/or check and see what your insurance will cover and this and that. So you know, in that sense, we're transparent in terms of that. And we've been doing that for years.

COMMISSIONER ERICKSON: I'm sorry. Could you say just the first part again, Bob? The hospital is providing?

COMMISSIONER URATA: No.

COMMISSIONER ERICKSON: Your clinic?

COMMISSIONER URATA: Our clinic professional fees will be "X" number of dollars for OB care because it's a global fee, one charge and then for routine, low-risk OB and that includes delivery, and you know, the nine or ten visits or whatever, plus the lab tests beforehand.

COMMISSIONER ERICKSON: And I'm sorry. I'm just multi-tasking, and it's not working. So did you say it was an estimate or are you actually charging them a single global fee?

COMMISSIONER URATA: That's a single charge, yeah (affirmative), for OB. Right, Jeff?

COMMISSIONER STINSON: And a lot of physician clinics, there is kind of a global charge for the things that they do the most common. So for us, for example, that wouldn't be difficult at all either. I think we, pretty much, have a global charge for things that we do, kind of akin to what Bob's talking about.

CHAIR HURLBURT: Allen?

COMMISSIONER URATA: Excuse me. The idea is that we put it on a piece of paper, give it to the patients at their first OB visit so they know what the charges are, and they can take it down the street and compare it with the next person or the other person, that kind of thing. But our intention is to let them know how much it's going to cost because we hope that, nine months down the line, they're going to have a baby and then, you know -- so we know what the outcome is supposed to be and this is how much it will cost.

COMMISSIONER BRANCO: Dr. Urata, this is Pat again.

COMMISSIONER ERICKSON: Go ahead, Pat.

COMMISSIONER BRANCO: Oh, thank you very much. I never quite know when to weigh in. Sorry about that. One of the things, when a patient can go down the street and compare prices, that's one thing, but when the providers, themselves, aren't able to get that information, we end up not being aware

of whether we're out of the price market or not. So this may be a backwards process in which we learn that we're out of the market range more accidentally than purposefully. We're prohibited from finding out the pricing of our competitors, even our collaborators. So it's an unusual circumstance.

COMMISSIONER ERICKSON: So.....

COMMISSIONER BRANCO: Yes?

COMMISSIONER ERICKSON: .....would you -- oh, I'm sorry. Allen, you had a comment and then I have question for all of you regarding a potential -- not suggesting a recommendation, but asking a question about one. Go ahead, Allen.

COMMISSIONER HIPPLER: It sounds like you had a follow-up for Pat. Why don't you do that first, while it's in your mind?

COMMISSIONER ERICKSON: Okay. Thank you. Along the lines of the concerns about anti-trust and not being able to share amongst each other, providers sharing amongst each other -- and it's come in a previous conversation in this group, and there were examples provided yesterday of other states that have imposed legal mandates on providers to disclose their prices. It overcomes the anti-trust barrier for providers then and is one mechanism for providing transparency for the public. So without trying to be too leading, is there -- does the group have a feeling about whether you would want to make a recommendation regarding a legal mandate that would be

imposed on providers to make their prices more transparent? And did you see any examples in any of the other states' legislation that does that?

COMMISSIONER BRANCO: I can.....

COMMISSIONER ERICKSON: And Jim has his hand raised and then Pat.

COMMISSIONER PUCKETT: Well, I would like to see it be a voluntary situation. I would like to see that's a voluntary situation rather than legally mandating it, and then if that's not going to work, then the Legislature can take up that question at that time.

COMMISSIONER BRANCO: Is it okay for me to weigh in? One of our closest neighbors has this in effect right now. It's Washington State. Sorry. I'm getting feedback from my phone, and I apologize for your hearing it. Forgive me.

But what we've got is Washington State mandates that hospitals report their pricing of their average (indiscernible - phone interference), average cost per discharge, average cost for admission, et cetera. So it isn't the individual procedure pricing that's mandated. That's usually only a penalty imposed by the federal government when anybody is caught committing fraud, such as Virginia Mason. Then they're forced into price disclosure, and I think the rolled up data, the generic data gives people a sense of who are the high cost providers in their community or within the state. Each month,

I get a list of providers in Washington State on this aggregated data on pricing and cost. I'm able to put our numbers into effect, and I find out that, on this comparison, I'm in the middle of the pack of Washington State hospital providers. It's fairly useful data to, at least, measure your performance or your pricing position within the market, and it's fair for consumers to see as well.

And so I would advocate rolled up data, and I don't mind mandated, but I certainly don't like a heavy-handed approach in which it's an unfunded mandate that requires hundreds of hours to produce the data from which we derive no benefit.

COMMISSIONER ERICKSON: Pat, could I, again, ask for clarification on that? In Washington State, is it -- I mean, it almost sounded like an All-Payer Claims Database, that they're taking aggregate data and producing average and ranges of prices.

COMMISSIONER BRANCO: No. It's not ranges. It's every hospital in the state, and it's run through the hospital association, not an All-Payer Claims Database. What it is, they mandatorily report to the hospital association specific financial information as average cost per discharge. That's one of the metrics that they use.

COMMISSIONER ERICKSON: Thank you.

COMMISSIONER BRANCO: And it's -- and I apologize. To get even more complicated (indiscernible - voice lowered),

average cost per adjusted discharge. So regardless of the size of the institution or the acuity of the patient level, it's a complex measure, but it gets to the point where they're comparing apples-to-apples.

COMMISSIONER ERICKSON: Thank you. Bob?

COMMISSIONER BRANCO: You're welcome. Did that make sense?

COMMISSIONER ERICKSON: Yes. It did. Thank you.

COMMISSIONER BRANCO: And actually, Deb, I will share that document with you sometime here within the next week, and you'll be able to look at all of the hospitals in Washington State and key this number in. I'd be happy to share it with anybody on the Commission as well.

COMMISSIONER ERICKSON: Thank you. I'll make it available.

COMMISSIONER BRANCO: You bet.

COMMISSIONER ERICKSON: When I get from you, I'll make it available to everybody.

COMMISSIONER URATA: When I was on the Board back in Juneau, we used to look at the discharge cost or cost of discharge, average cost of discharge that is available through Medicaid and that's how we used to compare our costs with the costs of other hospitals in Alaska. And so that might be available, but the problem, I think, is it's not necessarily comparing apples with apples. Providence and Alaska Regional

were always higher than us and so we would put ourselves in the category with Ketchikan and Kenai or Seward and Kodiak and try to compare, you know, our discharge costs with theirs, but I believe that should be available for all of us as well. Is that correct?

COMMISSIONER BRANCO: And Bob, the leveling of the playing field is (indiscernible - voice lowered) adjusted average cost per discharge.

COMMISSIONER STINSON: What's interesting is I'm not quite how they're deriving the data or how valid the data is or how valid the data is across several different instances, but it shows you something. Everyone is paying attention and trying to get -- they're paying attention. So if we're looking to control costs and enhance value, if we can get a good metric that people agree on, this is something -- one of the first questions was whether or not people are going to utilize the transparency. Well, if the providers do, that's a good first step.

COMMISSIONER BRANCO: And let me weigh in, too. Our Board, like Dr. Urata when he was on the Board of Juneau, used that information to make sure that we were not exceeding the market range. So even with adjusted price information or discharge cost information, we adjusted our prices increases annually, based on that information, to make sure we did not become the highest cost provider in our community or within

our region or within the state. So it was a conscious effort to maintain and control our costs, as a direct result of that information.

COMMISSIONER ERICKSON: Allen, did we.....

COMMISSIONER HIPPLER: Yes. I -- in light of this conversation, I would like to discuss a price theory a little bit, which everybody loves, I'm sure. Prices have a purpose. Ideally, they're supposed to be a way in a market economy for resources to be allocated efficiently. That's the purpose of prices. That only works if prices are related to an approach cost. So from my perspective, it seems like one thing the healthcare industry suffers from is a lot of cost shifting. That is to say, if certain procedures are over or undercharged, those procedures do not then reflect the costs, and prices don't work like they should. I just thought I'd point that out.

COMMISSIONER DAVIS: Thank you. So I'm really struggling with this, but it's -- I applaud the efforts that have been discussed from the provider side, to use the data that's available as a reasonableness test, but what strikes me is this -- that is really just the crawling -- averages -- it reminds me of the actuarial joke, you know, two actuaries playing golf, and the first one hits a ball 100 yards right, and the second one hits the ball 100 yards left, on average, they both got a hole-in-one, okay? They can be so misleading.

And what we have found in our work -- again, I applaud what Pat has described and what Dr. Urata has described because you're using what you've got, but what we've found in our work is, on average, this hospital, you know, falls in this category, but if you look at a particular service, like OB, you might find, wow, this hospital is, on average, good, but for OB, they are way out of line or vice versa. And so you really have to go beyond just simple averages, and it takes people, like Peter and healthcare economist actuaries, to say this is a real number that you can rely on. So if we're not -- you know, we need this information. We need it for a lot of reasons that we've talked about. We need good information, but if we're not willing to commit to getting to good information, then let's not do it because the unintended consequences happen.

And to Allen's point, you get things that are totally unrelated to the cost, the cover of the TIME magazine article, the acetaminophen pill. You know, the cost was, what, a cent-and-a-half, and you know, the price was something very, very different than that. So I just, you know, throw that out there that this is really hard work, if you want to get to meaningful price transparency, and we'll have to commit to that, if it's going to produce a beneficial result for the public. Thank you.

COMMISSIONER URATA: I agree with that, but you know,

that was the only data we had available to our Board was the Medicaid discharge, which was, yeah (affirmative), far and away, you know, kind of the minority of our discharges.

COMMISSIONER ERICKSON: Yes?

COMMISSIONER STINSON: So when we're talking about it, we have to agree upon what data, what information we need so we can make more intelligent, more informed, deep decisions, and actually, people like you, across the table from me, would probably know what kind of transparency to what depth and what kind of information needs to be collected, so that apples are apples and oranges are oranges, and I would defer to people with expertise in that field.

COMMISSIONER DAVIS: So if I may? So where we've settled in on that is that that prices for a particular -- now, it's complicated. So a global OB price is one thing. I mean, that's great. That's apples-to-apples. That's cool, but we get away from that. Where we've settled in is episodes of care, episodes of treatment, and comparing episodes of treatment across providers because then you factor in price and units of service and complication and all of those things to get to an episode of treatment. So you know, cholecystectomy. Here is an episode of treatment for this surgeon and this surgeon, and also, it factors in what hospitals they use and all of that. We attribute it back to the physician we can attribute it to. That's what we've

settled into. So I was thinking about, you know, mandating that people put their prices up doesn't tell you anything. Have you ever looked on the back of a hotel room door? You know, there is a price on the back of the door that, by law, they have to put there. No one pays that price, you know. It's irrelevant. And in medicine, I think there are, you know, exceptions, like a global OB fee where those are comparable, but that's not probably the right measure. But to get to episodes of treatment, you have to have a big enough sample size, you know, so that it's credible and that takes a lot of people, which is where, you know, having everyone in would be beneficial, but it's complicated to do it, but that is where we have settled in as a credible, comparable measure.

CHAIR HURLBURT: Let me maybe ask on that, so if you're looking at an episode of treatment group pricing methodology, you either have to have a big enough company that can do it yourself or you can go out to an Ingenix or somebody and you can purchase that. That's not something that an individual consumer, even with an HSA, could begin to think about doing. If you're a big payer -- and that could include the State of Alaska for employees and retirees or Medicaid or Premera or whoever -- it's worth it for you to either develop that internal capability or to buy it from somebody, and I absolutely agree that you have to do that, if you're going to be prudent in how you operate.

But that said, that's different than the posting of prices -- What is my colonoscopy going to cost? What is that going to cost? -- for the individual consumer. So they're really kind of two different things, and one of the options for paying for an All-Payer Claims Database would be for the State to pay for it with General Funds. It's not the only option, but it would be one of option. The episode of treatment group kind of thing would be something that the only way the State would pay for that would be as an employer or as a payer of another kind, like Medicaid. Would that be correct, would you think, Jeff?

COMMISSIONER DAVIS: Thank you. So this is what I tried to describe yesterday, sitting down in that chair. Blue Cross Blue Shield Association affiliated plans, the 19 plans cover 100 million Americans, and based on that data, we've developed these episodes of treatment for a whole bunch of things, not everything, but there are over 100. And it is out there on the private websites or the -- you know, for our customers, where they can go in and say I need -- I'm going to have a total knee, and you can look at, by physician, in whatever region you choose, what the episode of treatment for that total knee for that physician range is. So then that way, that is what we're putting out there for our customers to use to make their decisions, when it's appropriate to make the decision. It's not elective. It's not emergent, you know,

those sorts of things.

I agree with you, and perhaps, didn't state it clearly earlier, but posting prices for a particular thing is, in most cases, not helpful. Global would be, you know, notwithstanding. That's a great thing to do for transparency.

To answer Dr. Stinson's question, after a lot of work, a lot of people nationally, that is where we settled in as, for now, a measure that is useful and helps people make good decisions about where they should go. And the variation -- Alaska is not the only place with variation. You look in the Greater Seattle Metro Area, and even with a delivery, you can see a 200% variation, or even downtown Pill Hill Hospital is a 200% variation for OB. And you look at the next thing, you look at total knee, and it goes the other way.

So it's -- that's to my point about, you know, I applaud the efforts to use the average price information because that's what you had, but it can lead you to the wrong decisions, if you can't go to the next level and really look at specifically that particular service because, to Allen's point, prices are not related to cost. They're related to something else. Because there is no transparency and there is no competition, they can be whatever that provider wants it to be for that service.

COMMISSIONER ERICKSON: So what's the answer from the consumer's perspective?

COMMISSIONER DAVIS: What I'm suggesting is that that -- and probably because it's my bias is that, to go down this road and to get to something that's useful for the consumer, you've -- at least, the way the technology exists today -- to get to an episode of treatment type measure, and you know, that's not going to be perfect, and it's not going to be available in every market because of small sample size. But anything short of that, in my experience, doesn't -- it produces unintended consequences.

COMMISSIONER ERICKSON: So do we need an All-Payer Claims Database to get at that?

COMMISSIONER DAVIS: I think so. I'm not sure, but I think so. I don't know. You know, we can do that for our customers. Jim could -- he's big enough. He could do it for his customers, but to the point yesterday, what about the rest of us, you know? And so without that, I don't know how you get to data that is used by every Alaskans, and our goal is to have all Alaskans be the healthiest, not just Premera customers be the healthiest. So with trepidation, I think yes.

COMMISSIONER ERICKSON: Jim and then Larry?

COMMISSIONER PUCKETT: Just for a point of clarification for what it's worth, sitting here as an individual, if the idea would be that a patient could have a conversation with his physician, and his physician could give him a reasonable

estimate, and the patient would know what he was up against and he could make his decisions accordingly, but unfortunately, we're not able to get that way to that degree because of the varied price structure that the physicians have to have. And so in this chair, as an individual, I was looking at it from the perspective, what can we do so the consumer has information to make an informed decision? And if an APCD -- so I don't have to say all of it -- is one of the tools that we could recommend that would be available to the public, great. The question remain as to whether we're going to go that direction, whether it would really solve what we're trying to get here. I'm just simply -- I'm completely behind, get information out for the individuals so they can make an informed decision on their healthcare.

As a Health Plan Administrator, Jeff is right. We've got enough data. So even if the State does implement an APCD, we're going to be mining our data. There's enough there. We're going to be able to do it for our own, individual plan, and if an APCD is there and we can draw information from that to help, whatever is out there for the public, we're going to be mining our own data, and we're going to be making our changes in our plan -- I say our plan, the State of Alaska's plan -- so that we are the most effective with improving quality and outcomes and costs for our plan.

So just for a point of clarification, when I'm saying we

need to get information for consumers, I'm talking about the data, as a whole. As Jeff said, we'll give the information to our plan members for whatever (indiscernible - voice lowered) we think we need to do and for whatever we need to do to be efficient managing our own plan.

COMMISSIONER ERICKSON: Just an observation of what I've heard. It's interesting, and I think it's significant that Jeff just said, publicly, that you think you've gotten to the point where you would support an All-Payer Claims Database in other states, where it's a mandate; did you say that? I was going to say, did I hear you say that?

COMMISSIONER DAVIS: Reluctantly, yes.

COMMISSIONER ERICKSON: Reluctantly, yes; you would support it.

COMMISSIONER DAVIS: Yes, as a Commissioner.

COMMISSIONER ERICKSON: As a member of the Commission, because my understanding of the process in other states, the commercial insurers are the ones who have the mandate, the state law to report have been the most reluctant to get behind it, and it's been the provider community, understanding that the payers are the ones that have the data that they don't have access to, and this is one way for them to get access, who have advocated for and supported an All-Payer Claims Database. So that's an interesting position for us to be in, potentially.

COMMISSIONER DAVIS: If I may, that is why I made the point about being in that chair versus this chair. In this chair as Commissioner, my duty is to look at what's going to work for all Alaskans, from the -- bringing the perspective of a payer to the table, and it's from that perspective, as a Commissioner, that I don't see how we are able to bring transparency to all Alaskans without something like this happening.

Now back in that chair, my colleagues are not going to be really very thrilled with the decision. I don't know how much it takes to get this done. There are a few other things we're being asked to do by the government in Washington D.C., but that's not the charge that I have, sitting in this chair.

COMMISSIONER ERICKSON: Val?

COMMISSIONER DAVIDSON: So have we transitioned to the APCD conversation.....

COMMISSIONER ERICKSON: Yes.

COMMISSIONER DAVIDSON: .....because I think we agreed, at the beginning, that we were going to separate those issues, but it seems like we've jumped there. So if we have, let's just go there.

COMMISSIONER ERICKSON: Uh-huh (affirmative). Larry?

COMMISSIONER STINSON: One more question for Jeff. The episode of care, I king of -- I like the idea for apples-to-apples and then it cuts through a lot of variables, and I

think it addresses some of the other comments and concerns. I'd like to see either a definition or an example, I mean, just so I can understand it better. Jeff, I don't know if you could give an example to Deb, at some point, where she could send it out. Like, for knee arthroscopy, what is considered an episode of care? Is it the treatment, including hospitalization or a surgery center, and then six weeks' recovery? I would like to see that because, if that's what it is, that would seem to be a lot more valuable than just putting out numbers at different hospitals or numbers by different providers.

COMMISSIONER DAVIS: So there's a lot of actuarial science and magic that goes into that. I can attempt to get that and provide it, but it's my understanding it is what you just described. It is this person had a total knee done by this surgeon, and when we look at everything related longitudinally to that surgery, this is how much that case, that episode of treatment costs or this is how much that CABG costs or this is how much -- whatever. So I will get some further clarification around that.

CHAIR HURLBURT: And to some extent, it's a little definitional in that what your most interested in is the global charge, including the professional fee, the facility fee, the whatever, but you might have a reason for just looking at what's the episode cost for the facility, but

overall, you're usually going to be looking at the global fee because the surgeon's fee might be outrageous, but the hospital is only charging you $500 a day, so you're going to go there maybe, globally, but it is a little bit definitional, at least what I've seen.

COMMISSIONER DAVIS: Right, and it's not perfect -- sorry, Keith -- because the argument will be raised, well, yeah (affirmative), my episodes' treatment are more because I get all the complicated patients, and my buddy sends me the complicated ones because he knows I'm better at that, you know. So there is that argument, and you have to -- you know, at that point, you have to say we're not weighing in on that.

COMMISSIONER CAMPBELL: That led to my question. Is there any sort of outcome data tied to your episode? Okay.

COMMISSIONER DAVIS: There is social media tied to it, but not -- that's another whole morass.

COMMISSIONER ERICKSON: I want to see if there are any other comments specific to All-Payer Claims Database and what's captured in the draft right now, and for process and for timing, what I'm going to do is incorporate the notes that we've taken this morning, in the conversation this morning, into the next draft for this document and circulate it in the next week or so, and we'll continue the conversation. What I would suggest, too, because the -- we had -- one of our other learning sessions scheduled for this year is on how hospitals

manage their financial systems and accounting and how healthcare pricing works. And so it seems, to me, that this -- I mean, it's an issue that keeps coming up related to this conversation we're having. So if we could continue this conversation in the context of that other learning session, hopefully, we can maybe schedule that for our next meeting so it's still relatively fresh, even though it will be a couple months from now. Yes, Val?

COMMISSIONER DAVIDSON: I agree that we need to spend more time on this and probably not today because, I mean, there was a lot of information thrown at us yesterday, and I'm still sort of trying to process what those implications are, but one thing I heard yesterday that I still -- that just keeps haunting me of, what has the benefit been to the State and to the consumers of the State that have implemented All-Payers Claims Databases? So have they seen their health costs decline? Have they seen the quality of their healthcare improve? I mean, really, what is the problem that we're trying to fix? And if that's what we say we're going to do, then I would assume that there would be a corresponding trend in that direction for the states that have had All-Payer Claims Databases for a while.

And the other is I would also want to see what the Cost Benefit Analysis is for -- so for example, how many individuals have utilized that information? Is it 1,000

people in this state? Is it -- have people done 1,000 queries? Have there been 10,000 queries? Have there been 500 queries? So what's the cost per query for maintaining that system?

COMMISSIONER ERICKSON: Wes, Jeff, and Larry?

COMMISSIONER KELLER: On that point, your question assumes a short-term benefit. In my mind, an APCD may be a very long-term benefit. It is a change that is going to take, in my mind -- and I'm guessing, you know -- years before we see the result because it's inserting the market forces back into a system that has been devoid of it. So for what it's worth.

COMMISSIONER DAVIDSON: I guess I was assuming a long-term answer, but we would start that trend. If it truly was a long-term impact, we would start seeing some trend, at some point, probably within a few years.

The other challenge is, I mean, we have all kinds of price transparency with airline tickets. I haven't seen the cost of airline tickets go down nor have I seen the quality of that service improve. So I think that the question really goes back to this sounds great, but if we do something effectively, we also have to take a look back and say what is this going to cost, what's the utility, is it doing what we've asked, what we assumed that it would do, and what's our check to make sure that those assumptions are true.

COMMISSIONER DAVIS: So Val, I'm troubled by the same things you are, but here's how I get myself, at least partially, past that.

So I've described where we are now with our data, and as a result of that, things are possible that were never possible before. We are developing kind of a layer over the top program that will reward people for seeking out this information and reward them, you know, above and beyond what they would have done before. And Mr. Hanson yesterday, our new healthcare economist, you're right on track with that, you know. So people haven't used it, but we think, with this kind of program layered over the top of it, they will, but if we didn't have the data, this would not be possible. So that's one example.

The other is we're working with primary care providers in the market who are hungry for this kind of information. Say, okay, I have -- it's a hypothetical -- a patient who needs a total knee. I send them to this group and this group, but I have no idea where -- you know, which is -- the quality is equal in my mind. If I knew that this group was five times more expensive than this group, guess what I would always send to this group. And that's kind of the information we're trying to figure out how to get in front of the primary care doctor before they're making the referral. Again, if we didn't have it, that now advance, if you will, that drives out

waste would not be possible.

So I'm with you. I'm troubled by it, but without it, we can't -- this is what I was trying to say yesterday. Without it, we can't more forward. With it, then moving forward is, at least, possible to drive out waste and improve quality.

COMMISSIONER STINSON: I totally agree with Valerie, which I was really thinking about that yesterday and didn't have much to say. This has the potential to be a boondoggle. That's why I was interested in the episode of care. They may have been looking at the wrong thing. That's why I wanted to look. We need -- Alaska needs to be different, yet once again, we need to look at something that may be more helpful and possibly be more influential on the process, but I totally agree that, within two years, three years, if it's not working, maybe it should be canned.

But on the possibility just raw cost data is not effective enough, this other information -- again, as long as it's explained on the website and people have an understanding, that might be helpful. And the other thing, as we've already heard, that, at least, the providers seem to be paying attention. So if I've got two different surgeons to refer somebody for a herniated disk to and one is one-third the cost of the other and they're otherwise both equally ethical and skilled surgeons, I would be more inclined to send one to the lower cost provider, but we don't even have -- I

have no information like that.

COMMISSIONER MORGAN: I guess I'm now showing my age, at this point. If you look at the cost of airline -- I'm going to revert back to the airlines. If you go back to the cost of airlines to when they were highly regulated and their costs set through that regulation, through a reg board, you had a lot of planes flying with a lot of empty seats, but those costs were spread. If you actually take the two years before deregulation and then look at the cost per mile now, factoring in inflation, it did bring down the cost per ticket, but it was two -- two things affected it. One, so with deregulation, competition did spring up, but that competition was spurred by being able to set your rates and to go with the competition.

Now, the bad part of that was a lot of small communities suddenly didn't have an airline because it was not cost-effective to do it. It did what Allen said; it actually worked. So the market reacted to that.

It was sort of my analogy when I used to teach economic history, back during the Civil War, that the Gross National Product of the United States doubled between 1859 and 1867, and the main spur to that, besides a major war inside the United States were the railroads that connected the West with the East to bring products in and finished products out, but that was great because of the income change, that that development came, but ask the Buffalo how well that worked and

another group of people, which I won't go into.

So the point is, is there is always debits and credits, and there is always good and bad, but I think the whole discussion has been very good in that let's not make it worse, that whatever we do makes it better, but I find it really good that, even when it might be a little tougher on your own industry, you're thinking about that guy that was sitting out there yesterday trying to get a CT scan and couldn't get prices.

This email I just saw -- of course, we don't know the other side of this, but that just sounded bad. Now like I said, there's always another side to the story, but everyone around this table grimaced when they looked at that email that was passed around. So that's the balancing act, but hey, you know, we're paid so much to be on the Commission to deal with these things that that's the way it goes. Hey, well, I got this, this morning.

So anyway, let's not discount competition in markets, but on the other side, we're going to have do something here, in some way, without causing unintentional consequences and make it worse, and I think prudence is good, but we also have to look at this. And I think some demonstrations on -- I've done pricing in hospitals. I've done charge master work for many -- several years in hospitals and in primary care community health centers, and I even helped my father out in a five-man

dental operation, helping them do prices, especially with provider agreements with Blue Cross and some other groups.

So how pricing is done is a little voodoo here because there is more to the charges. There is a whole, big formula out here about how many units are Medicaid and how many units are not that are preferred provider, and it skews it, and it pushes cost -- it pushes subsidies on the other groups, and I, personally, worry, as we go through this process -- and I've seen it in the Lower 48 -- that, suddenly, the poor guy trying to get a CT scan is paying the full price, the full cost and some more because we have a large group that can negotiate a rate closer to cost. So it's going to be a rocky year, I think, for us to get through that.

CHAIR HURLBURT: Let me just finish up, maybe by going to back to Val's comment and Jeff's effort, I think, to help Val through her comment because I agree with it.

One of the things that disappointed me yesterday was to hear the response from Linda and Amy that it has not demonstrably made a difference in having an All-Payer Claims Database and that kind of set me back a little, and it gave me some caution.

And then one of the disappointments that I had, I felt that Freedman and Linda and Amy did a very nice job of putting the report together, outlining what an All-Payer Claims Database was, the upsides, the downsides, what are various

options between going all the way and not going all the way there, but we had asked them to tell us some stories about how it's worked in other states, and I didn't get out of that what I had hoped to get. I thought that was pretty light.

And so what I would suggest, maybe consistent with the concern that Val expressed and that Jeff really did and I have and I think most of us, is an assignment for Deb and me between now and the time we come back to this for us to try to reach out to folks in New Hampshire or Massachusetts or Colorado or some of the other states where this has been doing, maybe getting folks who are more involved in the middle of it and to try to come back with some data, but also with some stories, with some objective information, but also some subjective information. Is this making difference? Is this helping? And if we come back and say it's really not, you know, then we have consider what we're going to recommend, if we can say no. When it come out last year in Colorado, the media just talked it like it was the greatest thing since sliced bread, and you know, you can find out all this information now that you couldn't have. So I'm sorry, Deb, but I think maybe if -- that it might be a good way to respond.

COMMISSIONER ERICKSON: I am -- would like to invite Dr. Williard and Dr. Whistler to come up, and as they come up to the head of the table, just to summarize our next steps, I

will get the next set of notes from this conversation, incorporated into the notes you have in front of you, out in the next week or two. We'll work on -- make a goal of having our meeting in June, in part, devoted to that learning session on financing and pricing of healthcare services, and continue this conversation about All-Payer Claims Database and transparency and Hospital Discharge Database, and Dr. Hurlburt and I will do some additional homework to see what we can gather on all of the questions. I listed quite a few questions, actually, in the conversation today, but significantly, see what we can learn ourselves from some of the other states. Yes, Dr. Urata?

COMMISSIONER URATA: Just quickly, can we get more information on episodes of treatment?

COMMISSIONER ERICKSON: Yes. That's one of the things that is on the to-do list. Yep. There are a few things on that to-do list, too, in addition to what I mentioned specifically.

CHAIR HURLBURT: Thank you very much. I think this next session is going to be quite interesting. As I say, it's the first time since the Commission was started back in the beginning of 2009, four years ago now, that we have looked oral health areas, and we have two panelists here.

Dr. Brad Whistler is the State Dental Official, has been very active in dental public health, both within the state and

nationally, and has done a nice analysis for us.

And then Dr. Mary Williard is with the tribal health system and has been a very controversial person in the sense that she has been a real leader in developing the Dental Health Aide Technician Program, which has been so impressive in addressing some of the oral health needs of folks in the small villages in Alaska, building on experience that folks had in New Zealand and so on, but really bringing it to this country, and other parts of the country are talking about doing similar things now. I've visited their training facility out in Bethel as well as the one here, and I've been real impressed. So anyway, Mary, we appreciate the perspective that you're going to bring. And I guess, Brad, you'll start, please?

DR. WHISTLER: I'm going to start and sort of give an overview of dental in general with some slides in terms that are going on nationally and then I'm going to shift to some Alaska information. But in terms of your program, I'll just differentiate in terms of oral health and dental health, and mostly, what we're going to be talking about today is dental in terms of the teeth or dental decay. Oral health in general, we'd be talking about periodontal disease, avoiding tobacco for reduction in oral cancer and periodontal disease. We might be talking about congenital defects, like clef lip or clef palate, but I think both Dr. Willard and my presentations

today are more focused on dental decay specifically.

So I thought I'd give an overview of some things that dentistry shares with other things you've been looking, like physician expenditures and hospital services, but also some things that are unique to dental. And I didn't find information to compare dental education costs with medical education costs, but I suspect that dental education costs are higher, similar sort of training programs.

The other thing for dental students is, typically, they have to purchase their equipment as they're going through dental school. So they're purchasing hand pieces, hand instruments and all that as they go along, so tens of thousands of dollars of equipment in addition to the tuition costs.

Most dentists are general practitioners. About 79% of dentists are general practitioners. I'll go through the specialty list a little bit later.

A significant amount, about 40% nationally on average, of dental reimbursement is out-of-pocket. So later, I've got a slide, but there are more than double the number of Americans that lack dental coverage or dental insurance than there are those that lack medical insurance and that influences things in practice. Dentistry is more economically sensitive because there are more out-of-pocket expenses, and it also has made it where, in terms of other slides, dentistry, in many states,

has not been rolled into managed care. It's been a carve out, and it's because of the differences that there is not the same leverage with most dental practices, because much of their practice is private pay, to go into preferred provider agreements or go into managed care, and it's a balancing act between Medicaid reimbursement and dental participation in the Medicaid program.

So the other thing in dental practices, for general practitioners, about 78% of practices are sole practitioners. Now that could be in our larger areas where they're co-located in the same building, but it is still very common where it's a general practitioner in a building that they have purchased. And so they are the facility manager, they are the admin manager, and they're the provider all in the same field in terms of doing that.

Surgical model of care versus the move to an infectious disease model of care. Dentistry, traditionally, has been drill and bill. You're looking for dental decay on a tooth. Then you get in there with surgeon. You drill it out, and you put in a restoration. Well, a lot of the science now shows that, if you catch dental decay early while it still just involves the enamel and it hasn't broken through that enamel and gotten to the dentine, if you see that patient more frequently to try and change behavior, if you add topical fluorides, many times, you can get that tooth to remineralize

so that you're not actually having to get the drill out and work on that tooth and that's been a very slow shift in dentistry to move that direction, but dentistry is slowly moving that direction. And Mary's going to touch on that a little bit more in terms of the infectious disease model and what's going on with the tribal programs here in Alaska.

Mobility of dentists. There are sort of two pictures on that. In private practice where you buy a practice and you equip it for dentistry, dentists are not very mobile. They're generally going to practice in one location throughout their career. That compares, in Alaska, within our tribal programs or in the community health center FQHC models where they're on salary, the dentist really doesn't have a high investment in that practice. And so unfortunately, we see, in some cases, where our tribal programs and our FQHC programs take on a newly-graduated dentist, and by the time they're getting more proficient and more productive, they move out to private practice. So they aren't fully getting the efficiency of dentistry that you would see in a private practice with that kind of turnover.

Medicaid participation and treatment of other underserved groups. This is a national issue. Alaska fairs better than most states in terms of private dental participation in our Medicaid program, but in many states, less than 20% of the dentists participate in the state program and that was

highlighted nationally with a child death around the Washington D.C. area a few years ago. Deamonte Driver has been publicized, at least a lot in the dental world, where he was a 12-year old boy with a dental infection that became a brain abscess, and ultimately, he died of that dental infection. Well, part of it, during that time, another sibling in that family was looking for dental care; the parent had been calling, trying to find a dentist to accept Medicaid, was not able to find one, ultimately contacted the Maryland Medicaid Program. They started calling the dentists on their list, and they weren't finding dentists that were accepting new Medicaid patients. So it really sort of highlighted a lot of things around dental access and also the need to improve reimbursement in the Medicaid program and also more active lists around who was accepting new Medicaid clients, so children-in-need could get into services.

Dental insurance. Dental insurance, really, does not fit an insurance model. The disease is so prevalent, dental insurance is really a prepayment plan. So you're not spreading the risk because the risk is so high. Really, you're just sort of capturing the payments early, on a monthly basis, and then you're sending them out the door by the end of the year. And that may not be true on an individual level. There may be individuals that are at low risk for dental decay, but overall for the population, it's high enough that

it really does not fit an insurance model.

I mentioned already in terms of the number of Americans that lack dental coverage, and the other part is, nationwide, about 90% of dentists practice in metropolitan areas, and in terms of looking at rural, very rural farming type areas, less than 1% of dentists practice in those areas, and like physicians, what we're seeing is the dentists practicing in those areas are getting older, and as they retire, they are not new practitioners moving out there. So that's one of the national concerns.

In terms of cost of dental education, looking at resident tuition from 2001-2002 to currently, you can see it went from just over $88,000 to over $171,000. Non-resident dental education costs increased from just over $128,000 to $233,000.

One of the things that the Alaska Dental Society has been raising is the WICHE (ph) program in terms of Alaska students, and part of what the concern is, is that, with the cost of tuition and the debt that's going on in dental school, many -- you know, Alaska students looking to dental school without family resources to get in there, we're getting to the point that we're precluding students to be able to get in there to line up the loans to take on that kind of debt to go through dental school.

Those bottom bullets, here, show the mixed picture in terms of the American Dental Education Association. One in

four graduates in 2010 left school with more than $250,000 in student loans. And then about the same number, about one in four left with no debt or debt less than $100,000. So it sort of shows the difference of who is going to dental school, and I would say that's not uncommon in dentistry that it's the son or daughter of the dentist that's going to dental school, and the family is supporting them while they get through dental school, and often, once graduated, that's who takes over the practice when that dentist retires. But for some students, it's really getting unaffordable.

Sort of national discussions went on around, you know, sort of the moral obligation to treat care and why we get into healthcare professions. This is a slide from the American Dental Education Association again that kind of looks at changes and transition of what incoming dental students were reporting in terms of why they got into dentistry. So you sort of saw this change in terms of self-reporting, that it really had to do with the social aspects of treating populations to where it was really sort of a good career to get into financially. And so that's sort of been the discussion of how do we pick different dental students getting into school that feel more of that social obligation to practice in underserved areas and to see underserved populations. And so some of the schools have started changing some of their admissions criteria to address some of these

issues in terms of who is getting into dental school.

Dentistry remains predominantly male, predominantly White male nationwide. The big change -- the most dramatic change is more women going into dentistry, and these numbers would look much different if we were looking at first-year dental students. The percentage of female first-year dental students would be much higher than 14%. But the other change has been in terms of racial minorities, and the push there is that, typically, dentists from racial ethnic minority groups are more likely to accept Medicaid. They're more likely to practice in underserved areas. They're more likely to see other racial and ethnic minority populations. And despite a lot of push in this area, there has been very little change over the last two decades. The biggest change has actually been with Asian dental students going into dental school, but you know, for American Indian/Alaska Native, a very small percentage going into dental school across the United States.

So this slide is on the dental specialties. The most common specialties are oral surgeon and orthodontist, followed by pediatric dentists. And on here, I have the public health dentist, which is a small percentage, and public health dentistry is actually a specialty within dentistry. And while we have public sector dentists here in Alaska, at this time, I don't think we have any public health dental specialists in Alaska at this time, and nationally, that's a very small

number also. That's a dentist that's gone back to school to actually specialize in treating underserved populations and also address water fluoridation, sealing programs, and all that. I have some information on Alaska specialists later.

Out-of-Pocket Expenditures. I already mentioned that about 40% of dental comes from out-of-pocket expenditures. This is out of the Bureau of Labor Statistics. But dental expenses are second only to prescription drugs for out-of-pocket expenses in the United States.

So the next emerging issue that we're going to be hearing probably more about in the dental world is with seniors, and with the baby boom generation and the demographics there, Medicare does not cover dental procedures. They cover it if it's related to trauma or other conditions, but routine dental procedures are not covered under Medicare. So as retirees retire out, if they don't take some sort of what was employer-based coverage with them, they lack dental coverage at a time that more seniors have most of their teeth. So if we were looking prior to World War II, you know, most seniors probably would have been (indiscernible - voice lowered) and in dentures by that time, but this time, even from our Alaska data, it shows that most of the 65 and older population in Alaska have most of their natural dentition. So to the extent that they don't have health insurance later, that's going to be an out-of-pocket expense.

Dental expenditures nationwide. This is 2011 information, but $108 billion. It's approximately four percent of U.S. healthcare expenditures. You've got the increases there. Out-of-pocket spending and the inflation increase is about a 4.1% increase in 2011, a 0.7% increase in 2010.

In terms of looking at net income and gross receipts from dental practice -- and this is national information from the American Dental Association, but average net income for general practitioners was just over $192,000. Gross receipts for that kind of practice was just over $700,000, average dental specialist income, $305,000, and gross receipts for a dental specialist just over a million. And typically on that -- I don't have breakdowns for the specialties, but typically, the high end would be pediatric dentistry, oral surgery, and orthodontics. Orthodontics is probably the highest in terms of gross receipts in the dental specialties.

So here is the trend chart, and it probably -- you know, on a lot of healthcare expenditures, you've been seeing these same kinds of charts with it climbing. I believe this one is actually -- this one is not adjusted for real dollars, but some of the later ones are. This was a chart -- it's a little bit busy, but this was looking in real dollars in terms of what's gone on with mean household incomes over the last several years. You see the dip in terms of the national

economy, in terms of adjusted household income dollars.

So I'll show these next slides that are for the same period, and if you look at this, this chart in terms of the solid black line that's going above and below is dental visits.

So one of the things that happens when the economy downturns is people delay dental care. Those that might have gone in for a self-pay basis will differ care. Of course, the problem with that is that they weren't missing the opportunity to sort of prevent that decay, if there is the early sign of an enamel lesion, where we could be getting into more complex procedures as they delay that care.

This is showing dental income in terms of adjusted dollars, and you also see that dip in terms of adjusted dollars. So while total expenditures have gone up, you know, inflation adjusted dollars to a dental practice actually did dip with this recession. And I think one of the things we'll talk about later is Alaska benefitted from that, at least to some extent. Mary can talk about this more, but traditionally within the tribal programs here in Alaska, about a third of the dental positions would be vacant in a given year. We had two years that there was almost full, you know, dentists coming in to take those practices because things didn't look so good in the Lower 48, but they moved into Alaska. Although as a recent sign the other way, at least for one of the health

corporations, YKHC, which had most of its dental positions staffed, at the Dental Chiefs Meeting this last year, they were down to three dentists. So I think that, you know, people do move on, and sort of as the U.S. economy ticks up, it's a question if some these dentists that we've attracted that are practicing in community health centers and tribal programs are actually going to stay here in Alaska or they're going to move south after they've met their home repayment obligations.

Dental expenses as compared with general inflation, it's higher. I think that's true for most medical expenses, so I think you've seen those kind of charts before.

This is a chart showing by payment coverage and sort of the projections forward. This shows, you know, that it has dropped slightly in terms of out-of-pocket expenses. That's the blue line that's on this chart. The projections forward are expecting lower out-of-pocket expenses, and part of that is earlier change federally, in terms of the Children's Health Insurance Program or what we generally call Denali KidCare here in Alaska. There were some states that did not do Medicaid expansion in the Children's Health Insurance Program, and there were a few states that did not include dental services for children as part of their Children's Health Insurance Program. With the reauthorization of the Children's Health Insurance Program, they're mandated to cover dental. I

think some of this also is based on the projections with Medicaid expansions (indiscernible - voice lowered) and that is the primary public source that's expected to increase for dental care because, like I said, there really is no discussion about adding dental benefits within the Medicare program now. I think some senior advocacy groups are interested in that, but there really is not any momentum behind that effort.

This is an article from *The New York Times*, and I'm going to dispute a little bit what's on here, but this was sort of making the point of more spending and less -- and more disease in the outset. I think the real trend in dentistry has been, as far as dental decay since the 1960s with fluoridated toothpaste and water fluoridation, that, as a population, we have less dental decay, but expenditures were continuing to go up. And in the mid-1980s, you know following the recession that we had at that time, that became an issue in dentistry in that it was felt we were producing too many dentists. We had our peak number of dental graduates in 1983 in a slow economy, and there was sort of, in dentistry, what was called the business factor where dentists were not very busy. Some were getting back into sealing teeth instead of having the dental hygienist do it because there just weren't enough patients to see in the practice.

As a result of that, there were seven dental schools that

closed in the middle 1980s. Other schools reduced enrollment. So for our two closest schools -- University of Washington, I think, used to have 100 students; they dropped that down to 80. Oregon Health Sciences University dropped their class size down from 80 to 60, and I think a number of other schools did that same mechanism. So we saw changes in terms of the number of graduates coming out.

The one point on this chart -- what I sort of question on this is this is information from the National Health and Assessment Nutrition Survey that's used by CDC, Division of Oral Health. They're only using the last two years of that survey. Usually, CDC uses a four-year average, and the next chart is a CDC chart. When you look at this one, really, the only one there was an up tick in dental decay in very young children within that four-year average. So I think the charts in the *New York Times* article are a little premature in that there may be increases in other age groups, but I really think there needs to be a couple more years' information in that average, because of the number of people by age group, to see if that's true in older children and adults, that dental decay is actually increasing.

This is looking at dentists per 100,000 population. And in terms of doing that with that wave of students coming out, you see sort of the peak in the late '80s, early '90s in terms of the dentists per U.S. population and then falling off after

that. This chart is labeled in terms of a congressional report that was done in 1991. The information is from the American Dental Education Association again, and they actually used other data. So this was done in about 2001. I compared with what I could find online for 2005, 2010, and those projections are pretty much right on with what we see in terms of dentists per population now, nationwide.

This is a chart from the same organization that's looking at graduates versus projected retirements, and it shows that we're coming into a phase nationally where there are going to be more dentists retiring than those coming out of school and that's expected for several decades. And the implication is that, for what we have for dental access now, there are some serious concerns around what that's going to be as more dentists retire, what it's going to be in rural areas, what it's going to be for underserved populations that already have limited access to dental services now.

So now switching, a little bit, to Alaska information. 2009 I'm using in terms of the number of dentists, 465. We're probably closer to 510 to 520 now. It's out of the professional licensing files, but those are in transition, where they have -- for some dentists in that database, they still have their specialty dental license and their general dental license, so there is double counting. They show far more dentists than I know there are in Alaska, and there just

wasn’t time to get that whole list and start going through to eliminate duplicates. So I would guess that we’re somewhere around 510 to 520 now, but in 2009, we had 465 dentists that listed Alaska addresses on their professional services license, 233 of those in Anchorage. Orthodontists. You might wonder how we could have three-quarters of an orthodontist and a quarter of a pediatric dentist. There is actually one dentist that has both specialties, and they practice one day a week as a pediatric dentist and the rest of the week as an orthodontist. But this follows similar trends for the specialty groups.

So like I said, and as I said right now, for the specialties, I don’t think we have any pediatric specialists -- public health specialists in Alaska now, nor do we have any oral pathologists in Alaska. For dental population.....

CHAIR HURLBURT: What do you do (indiscernible - away from mic)? I’m asking, how are you handling the non-Alaska license that is practicing in Alaska, like in the military or the PHS (indiscernible - voice lowered)?

DR. WHISTLER: Sure. Well, at this point, because most of the dentists are direct hires within the tribal organizations, most of them have Alaska licenses. So there is less of a problem there with dentists practicing in the tribal health organizations that we’re not counting because they don’t have a license in the state. There is some of that

still, but most of the dentists do have an Alaska license.

With the military dentists, we really haven't tried to account for that, in terms of what's going on, on the base and that number of dentists and that would be a much smaller number than those working with the Native health corporations.

CHAIR HURLBURT: But then do you include the military population that is included in the Alaska population in the lower ratio?

DR. WHISTLER: We would be, to the extent.....

CHAIR HURLBURT: That's what happens with physicians is they don't get counted in one place and they do another.

DR. WHISTLER: Yeah (affirmative). The population numbers are as reported from research and analysis in the Department of Labor. So to the extent they're counted in those numbers, yes, they are. But the other part, when we look at -- when I get done -- these population ratios -- and Mary, you can correct me if I misstate this, but I believe there are about 80 positions within the tribal programs in terms of dentists practicing for tribal organizations. If we carved out the population that they serve -- and I don't have exact numbers because many Alaska Native adults and children in urban areas actually go to general practitioners instead of going to the Native health corporations. So I can't really get a precise estimate on that, but I think our Alaska numbers would move closer to national. I think there are still more

dentists per capita in Alaska than there are nationally.

One of the -- well, there are two things that drive that. I think, one, that there is more dental insurance in the market in Alaska so we can support more dentists. In a percentage-wise basis, there are more public employees. Most public employees have dental insurance. Traditionally, the strong labor unions in Alaska also had dental insurance. So while I don't think it's true anymore -- I'll just finish this statement; I'll get there -- I know that IBEW or the electrical union used to have two dentists that were specific for that union here in Anchorage, and it used to be that the Teamsters Union actually had its own dental clinic over at Alaska Regional, and I believe they employed, like, ten or 12 dentists during the heyday of the pipeline era. Now, I don't think that's true anymore, but traditionally, the unions have had dental coverage and the public employees. So that supports it.

The other part, for the tribal programs, is there is less efficiency in the dental model where you're doing itinerant dental visits because you're losing part of your dental time in terms of that transportation and set up of equipment. So again, Alaska is going to be a little bit different, but I don't think you can argue that, on a per capita basis, we have more than the national average of dentists. Yes, sir?

COMMISSIONER CAMPBELL: How do you the dual licensure?

Somebody who has got a license here, got one in Iowa or Wisconsin or something like, do you know where they're actually practicing or you just assume, if they have a license here, you're counting them?

DR. WHISTLER: What we're doing is we are only -- on this number, we're counting those dentists that listed an Alaska address on their license. So the presumption would be that they're predominantly practicing in Alaska.

And then I don't know -- for format here, there was a question from the audience; do we.....

(Pause - background discussion)

DR. WHISTLER: And then the last thing.....

(Pause - background discussion)

DR. WHISTLER: Okay. And then the last number that I had mentioned is the Health Resources and Services Administration typically uses a 1 to 5,000 or 1 to 4,000 in terms of high needs populations in looking at designating underserved areas and that's sort of what's looked at for getting community health center in the state.

And I would just share, in the course of discussing water fluoridation in Alaska, Dr. Hurlburt had mentioned the Parran report. So I pulled it up and skimmed through it real quick, and if we looked in 1954, at that time, there were 43 practicing dentists in Alaska. That would have been squarely within these HRSA estimates. So in terms of the 54, we

definitely were way low statewide in terms of the number of dentists. We've increased access, but along with that, then it brings up the issue in terms of expenditures have also increased in terms of dental care.

Demographics of dentists in Alaska. We looked at 2000 and 2008, and you can see the shift towards the red bars, which shows an aging dental workforce. Certainly, 25% of the dentists in 2008 were age and over, that, by that age group, we do see dentists start to retire. We see some dentists start to retire in their mid-to-late 50s. So we have the same concern in Alaska in terms of, for what we have now, we may see more retirements than we see new practitioners, and I'm working with another section in the Division of Public Health to update these numbers because I'm curious. With the downturn that we saw nationally in 2009, sort of, we may have seen some shifts on this. I doubt that it's changed. I'm sure the demographics are still shifted towards the right where there are more older dentists, but we may see more practitioners and more recent data in those younger age groups.

So changes that have gone on in Alaska with dental workforce. That last slide covers the first bullet here in terms of retirements that we may see. We're in the very early phases in our state of looking at trying to get more medical provider collaboration to reduce early childhood dental decay.

The issue there is that most general practitioner dentists are going to see children typically at age three or four. For children that get into problems with dental decay, that's too late. Typically, you want to be seeing them age one, no later than age two to catch those while it still just involves the tooth enamel. And so it's -- and medical providers are seeing those children for well child exams and immunizations, so there is an opportunity, if we enhance, sort of, the triage that our nurses and physicians can do to catch things early and refer those children to a dental practice early and avoid some of the other costs that are associated with that.

We have seen expansion of community health center dental programs. It used to just be the one major program here in Anchorage. In terms of urban areas, we now have them in Fairbanks, in Kenai/Soldotna, out at Talkeetna. SEARHC operates a homeless dental program there in Juneau. They're doing operations in Haines. So we've seen that kind of expansion.

The other big change in Alaska is the Alaska Native Medical Center is now doing a pediatric dental residency program. And so with having that here in Alaska, we've already benefitted from three new pediatric dentists that are practicing here in Alaska now as a result of that program, and it's a big impact for the Medicaid program because our pediatric dentists are definitely our high end Medicaid

providers for children's dental services.

The Tribal Dental Health Aide Program -- and Mary is going to cover that, so I'm not going to say, you know, much about that here -- the slow shift in moving from a surgical model of dental to an infectious disease model that I touched on, and then another change that's in the very early stages, legislation was passed for dental hygiene practice under collaborative agreements. So this would allow a dental hygienist that's working under an agreement with a dentist to practice in underserved locations without the dentist physically being present onsite. It offers opportunities. If we want to look at school-based programs, if we want to look at getting into assisted living facilities or long-term care facilities for screening and triage, and also topical fluorides and other things that can produce the level of disease, that's a more efficient model than if we're going to try and rely all on dentists to do that under contracts to get into those areas, but as I said right now, I think, right now, we have three new dental hygienists that are practicing under this, and they're focusing on long-term care. So this at the very early stages of this model in Alaska.

Looking at dental decay -- and I think, on these slides without memorizing numbers, the big thing that is different in Alaska is we do have higher rates of dental decay. Caries Experience scores is what I'm showing you. Caries Experience

means that we're scoring. Whether the tooth is untreated and there is a cavity there, a hole in the tooth, or the filling is in place, that's Caries Experience. So it just means there has been past or present decay when you're doing the screening.

This particular slide is looking at Head Start children, which, because that selects for a low income group, is going to be higher than for than for all children in that age group, but it still -- when I've seen Caries Experience scores from other states, we're typically double the level in the state in terms of looking at dental decay in the Head Start program, and higher in the American Indian/Alaska Native population.

This is looking at kindergartners. When you compare nationally, Alaska is higher. We're not quite as high as this slide would indicate because the national baseline is two to five-year olds, and of course, with kindergarten in Alaska, we're just look at five-year olds, but we're clearly higher than the national average. It's higher in the American Indian population. Consistently, when we've done these scores, although there are smaller numbers of children in the screenings that we've done, we've consistently seen higher rates of dental decay in Asian children and Native Hawaiian/Pacific Islanders, and typically, its level is close to the Alaska Native population.

I don't think I brought any slides in terms of untreated

dental decay, but in the untreated dental decay scores, it's actually higher than the Alaska Native population in those groups. The Alaska Native population has a mechanism in place to treat the disease once it's there, whereas these other groups are not quite as connected with the healthcare system, and they're not getting their dental decay needs met in terms of dental treatment.

Let's see. This is -- I'm sorry. That slide was kindergartners. This one is third grade, and it's similar patterns. In the older children, not as striking in terms of differences from the national baseline, but we see the same pattern, higher rates of Caries Experience scores in the American Indian/Alaska Native population, higher Asian, higher in Native Hawaiian/Pacific Islander.

So other high risk groups for dental decay, low income children. In general, income level is a risk for dental decay. It's also a risk for periodontal disease. And so the Medicaid program and Medicaid access is one of the concerns. Low income seniors is a concern, and I think that's one we're going to be facing more with, you know, Alaska increasing at three times the national rate in terms of the 65 and older population, that this is going to become more of an issue.

Children and youth with special healthcare needs and adults with disabilities. In our urban areas, we do a pretty good job with children and youth with special healthcare

needs. The pediatric dentists are the primary providers for those. Not as well, even here in Anchorage, for adults with disabilities. In talking with the pediatric dentists, we ran into several examples of pediatric dentists that were treating 40-year olds in their practices because they did not have a mechanism to refer them to another practice for care. So that is another area where, you know, the Trust is interested in this, also in terms of expanding access to dental care for adults with disabilities. The situation, of course, is worse in rural Alaska because there is not direct care in those areas, and most of those children have to travel to get services.

This is a slide on our Medicaid dental utilization. Overall when we look at children ages one through 20 in the Medicaid program, about half get a dental visit in a given year. The treatment aspects in terms of getting dental treatment are lower, so it's really sort of the treatment services we want to bring up. With our rates of dental disease, and especially early childhood caries, we need marked improvement in terms of those one and two-year olds getting dental care. In terms of what we hear from the tribal programs in terms of the number of children that were taken to the hospital OR for general anesthesia and treating their dental needs, we should really probably be more in the 50% to 60% level, even in these one and two-year olds, at access to

dental services.

This is looking at trends in terms of dental access, and if you look, the up tick that was seen in ‘99 is the result of expanding in terms of the Denali KidCare Program and more children getting dental services in that area. Since that time, it’s been relatively flat in terms of any dental service, preventive service, or treatment services. You’ll notice, in 2010 and 2011, there is an up tick in terms of doing that. That actually is a reporting artifact in terms of how they capture the information.

In 2010, the Federal Medicaid Agency went from collecting dental visits on any children enrolled in the program to only collecting this information for children that were continuously enrolled for, at least, 90 days. That actually -- the way they’re doing it now is a dental measure because, if a child was only on the Medicaid Denali KidCare Program for a month or two, it’s extremely difficult that they’re going to meet a dental visit during that period. It’s not uncommon to have a month to two-month wait for dental services, even with private insurance, that there is not immediate access to get them in for services.

So fees and reimbursement, and on this, I have limited information. In terms of what I have is what’s available in the Medicaid program. There is also an American Dental Association Survey that they do on dental fees, and I have

some information that was provided from Retirement and Benefits on some common dental procedures, and Retirement and Benefits looked at, over a two-month period, sort of what they saw for dental claims in that area. But if you look at this, it's the -- in a PEW report card -- they did a report card in 2010 scoring state programs. It was primarily around Medicaid reimbursement.

Alaska scored an "A" on that, and one of the Medicaid policies that assisted with our grade on that report is Alaska's Medicaid reimbursement rates are about 90% of the national median charges for dental when you look at national reimbursement and compare those with the Medicaid reimbursement in this state. But as you look at regions within the United States, the Pacific Northwest Region is a high cost area for dental fees and that region is about 15% to 20% higher than the national average, and Alaska is part of the Pacific Northwest Region in that ADA survey.

And when you look at -- in terms of looking at the averages from Retirement and Benefits, Alaska is about 10% to 15% higher, on average, than the Pacific Northwest. And then when you look at the maximum allowable for these common dental fees, it was anywhere from 45% to 75% higher than that. So what you see is Pacific Northwest is higher, on average, than the national, Alaska higher than that, but there is a wide range in terms of dental fees on top of that. So when you

look at Alaska in terms of this maximum allowable, we're getting where we are up there at 50% to 75% higher than the national average, by the time you look at our higher billing dentists within the state here.

So other healthcare costs, and this is sort of if you don't do something about dental care with young children and early childhood caries, you can have issues with speech development. If those upper front teeth are lost early -- and we use the upper front teeth a lot with the English language -- you may doing speech remediation later. But a big cost is treatment of severe Early Childhood Caries with facility expenses and general anesthesia as you take those kids to the OR to extract teeth, do stainless steel crowns or remove the pulp of teeth where the infection has gone to the pulp.

One of the other things around there is emergency room use. We hear this a lot in states that don't have adult Medicaid dental services. About five years ago -- and it was about the time that Alaska was actually authorizing increased adult Medicaid dental services -- the Medical Director from Providence Emergency Room came to one of our coalition meetings. He indicated, at that time, Providence was seeing three to four people a day for dental conditions in the emergency room, and the concern was that, if the tooth needed extraction, they had agreements with oral surgeons to go ahead and get the tooth extracted, which was removing the cause of

the disease, but in many of these cases, that wasn't the issue. It could have been a periodontal abscess. It could have been dental decay. And in those cases, they're giving the pain medications, and they're giving the antibiotics, but they're not curing the root cause of the problem. So that person goes home and they're asymptomatic for a while, until that tooth blows up again and then they may very well be back at the emergency room again, and most of those cases were uncompensated care.

So building networks, I think there was very early discussions -- I don't think anything has been in place, but here in Anchorage, possibly the Anchorage Neighborhood Health Center might develop contractual relationships with the hospitals, so there was a referral mechanism to get other dental needs met, which would reduce some of our hospital costs in terms of doing that.

Medicaid transportation. And I think the Medicaid program is starting to look at this more, but many children in rural Alaska are transported for dental conditions and so those travel costs are associated with dental.

And then nationally, there has been a lot of highlighting in terms of complications with other chronic disease, in terms of birth outcomes, cardiovascular disease, and diabetes, and all this is mostly around periodontal disease. The strongest link is actually a reciprocal relationship between diabetes

and periodontal disease in that individuals with diabetes are more likely to get periodontal disease, uncontrolled periodontal disease, and it's hard to manage the blood sugar levels in the patient.

So in terms of cost management or looking at things, I think one of the things that's lacking in private insurance and also in the Medicaid program is we really don't have a mechanism to look at the past case history of a client. What we know is what was done by the dentist, but we don't know the condition of the patient that presented to the dentist. So the reality is, you know, we don't know existing restorations. If you're really trying to manage things, as restorations are replaced, we only know what the system paid for and if we paid for it last time. We don't know, you know, how many times we're doing restorations on the same tooth because they failed.

Diagnosis codes have not been used in dentistry. That's scheduled to be implemented soon, but that lacks in terms of using some of the administrative data. As an example, when a tooth is extracted, we don't necessarily know if that tooth was extracted because of trauma, if it was extracted because of periodontal disease, if it was extracted because of dental decay, if it was extracted because it's for an orthodontic service. Now, the orthodontics we might guess because of the age of the child, but that's just one example. I think the

administrative data relying on that for health policy would be better as we implement these diagnosis codes.

For the Lower 48, in terms of managed care, it's been very hit-and-miss at integrating dentistry into managed care. As I said, there is not the leverage with dental practitioners to really put them on a per patient, per month basis and make that work, so many dentists have just opted out of going into managed care. Many of the states that started with managed care on dentistry have moved to a carve out and gone back to other mechanisms of funding for dental practices.

There has been a development of dental plans. DentaQuest is now a big national group that's taking over some of the state Medicaid programs for managing dental expenses, and they're moving more back to a little bit of a managed care environment, but for the most part, dentistry has not been as impacted by managed care as physicians and hospitals.

And establishing a usual and customary reasonable fee. And I would just mention, in terms of Retirement and Benefits pointing me to a Plan Administrator that worked on dental -- and I don't think this is unusual -- there really is not as much pressure on managing the cost increases in dentistry. What the person told me is that, for most of the routine dental services, they're going to go by what the dentists charge in establishing what the UCR rate is going to be. If they start to tighten down on that, what they hear is a lot of

patient complaints as they get those, you know, above UCR or higher out-of-pocket expenses for state employees. So it really is, you know, like a crown and bridge are more expensive things. There is more oversight and control on that, but routine restorations and those kind of fees, it's sort of just going with what the market does and increasing those rates accordingly year-to-year.

And then Medicaid reimbursement. In Alaska, we ended up -- for 1997 through 2007, we had not increased dental reimbursement for most of the common dental procedures, and we were seeing that that was impacting dental participation in the program. The Legislature authorized increases in 2008 and 2009, and we were able to get most of the reimbursement backed up to the 70% to 80% range of the average dental charge in the Medicaid program at that time, and then in regulatory changes, it's now where the Department indexes the dental fees to Anchorage CPI each year, you know, to the extent funds are available to try and track what's going on in the market in the Medicaid program.

COMMISSIONER PUCKETT: Maybe you just said it and missed it. When do they expect to have those diagnosis codes for dental procedures, if you know?

DR. WHISTLER: I have not a firm date. I think that they're in the process of implementing them on the dental claim form, but the other part is that there will be a field

on there, but I don't necessarily know that there are mandates that are going along with that field -- is going to be utilized.

And the other question that I brought up nationally that's not as clear to me in terms of what they're looking at is I see some -- there is useful information both with, if we can use -- they're looking at ICD codes, ICD-10 in terms of the codes that would be on there, both for dental diagnosis, but there would also be some usefulness for things like a diagnosis of diabetes on the dental claim form. So for instance, from a healthcare perspective, we would like individuals with diabetes to, at least, be in once a year and maybe more to manage what's going on with that periodontal disease. You'd have a link on the form then that you could actually set up your system where we would automatically allow more frequent visits for persons with a specific medical condition, why there is a dental reason of why they could get more often, but I think we're still several years off before we're going to see exactly how this is all going to work.

So in terms of ways to reduce dental expenditures, number one most cost-effective approach is community water fluoridation. I put a slide up of enamel fluorosis. In terms of the public health side of dentistry and what's going on with water fluoridation and changes, this is the real kind of balancing act is that water fluoridation reduces dental decay.

At the same time, water fluoridation increases the risk for this white flecks in tooth enamel. And so with that, it used to be we gave fluoride supplements to infants growing up in areas without water fluoridation from the time they were born with drops and stuff. That changed to where, now, we don't do that until six months of age, and if fluoride is even elevated a little bit, we delay that longer because these permanent front teeth are developing about the time of birth, and they're fully mineralized at age two. So if it's a low risk child, a child in a family that not at much risk of dental decay, then we want to shift towards the side of not causing this white flecking in tooth enamel. There are similar guidelines out around toothpaste, that, if you're child is very low risk for dental decay, maybe you should delay using fluoridated toothpaste until after age two.

Now on the other side of the coin, that doesn't mean that child at high risk don't need fluoridated toothpaste. In the high risk group, we want that fluoridate toothpaste right away. We want to control the amount, but the risk is much higher for the dental decay aspect. And so this is being used by fluoridation -- it's one of the arguments that being used by water fluoridation, and they're portraying this cosmetic effect in tooth enamel as a sign of toxicity in children, that water fluoridation isn't safe for children, and it's one of a long list of arguments, but this is the only real argument, or

you know, that's going on within public health dentistry.

So looking in terms of costs, even with the use of fluoridated toothpaste now, which most people use fluoridated toothpaste, water fluoridation is shown in studies to reduce dental decay in children by about 29%. It's shown to reduce dental decay in adults by about 27%. And the big issue for Alaska, of course, is that many of our communities have been moving the other direction in Alaska. So Juneau went off fluoridation in 2007. Fairbanks went off fluoridation in 2011, and the most recent community was Palmer in November of 2011 that discontinued fluoridation. So we're moving the wrong direction on that in a state that already has a higher rate of dental disease. So that's of concern.

Fluoride supplements. Fluoride supplements are now a risk-based approach for that same reason in that, when you swallow a pill or you take a drop of fluoride, your blood level of fluoride spikes, you're at increased risk for development of that enamel fluorosis picture that I said. So again, the balancing act, low risk child, we're not going to do fluoride supplements anymore. High risk child, absolutely, we want to do them. The biggest problem is compliance. They're daily. And so in terms of doing that, if you can try and get your kids to brush their teeth everyday when they're young, you know, it's that compliance aspect that really limits the usefulness of that and then topical fluorides, and

the movement with young children has really been towards fluoride varnish, which was a product that was developed as a liner for a cavity preparation before you put in the filling to reduce hot and cold sensitivity, but it has fluoride in it, and it stays in the mouth for a long time. You paint it on the teeth. There is an elevated fluoride level of three to five days that you're benefitting and the tooth is remineralizing during that period, if you can change around the diet at the same time. So Mary is going to talk about other aspects in terms of infectious disease, but this is one of the approaches for doing that. There are other therapeutic agents that you can use to reduce the bacterial activity that causes tooth decay. I'm not going to touch on those a whole lot. I just listed a few.

School-based dental sealant programs, this is -- besides water fluoridation, this is the other evidence-based approach to reduce dental decay in the literature, and the model is going into schools that have high percentages of low income children, and as the first permanent molars erupt -- so typically, you're doing second graders -- putting resin fillings in the grooves of those teeth to preempt decay. First permanent molars of the tooth, that's most likely to decay. It's also the most likely tooth that, other than your third molars, those are extracted, you know, in terms of doing that. It's the most likely tooth that you're going to lose

due to dental decay. So many states have school-based sealant programs. We have just started this with funding through CDC and HRSA. We've done, now, four years at an elementary school here in Anchorage as a pilot program to see what would be involved in doing this. With funds that we received from HRSA this year, we've expanded it to another school here in Anchorage, a school out in the MatSu Valley, and one of the schools up in Fairbanks. Total, I'd have to look at.

We have about approximately 20 schools in Alaska that would meet this criteria and have, at least, 50 children, and the 50 children part is important because there are a lot of logistics involved in doing this, and as with other things in Alaska, this requires active parental consent. So our experience, so far has been, in terms of that requirement, to get the form back from the parent that allows us to do these services, we only get about 40% to 50% of those consent forms back. So if we go into a school that's got 50 second graders, typically, we're only going to see 20 to 30 of them in this program for all the logistics. So we're really not looking at doing this in schools that are, you know, 25, 20 kids because it's just -- all the logistics aren't involved with how many kids we're going to see in that aspect.

In terms of nutrition, there has been a lot of discussion around soda and sugar sweetened beverages. There is a study that was done by CDC, Arctic Investigations here in Alaska, in

2008 out in rural Alaska that showed both the reduction in dental decay with water fluoridation, but it also showed increased dental decay with reported soda use, and they didn't look at all sugar sweetened beverages. They looked specifically at soda, but I would say that, in my time working for the state, what I hear from dentists practicing with tribal programs I mostly hear soda is that you're hearing about the kids that are drinking five-six sodas a day. I hear the public health nurses that have talked about getting bumped from cargo planes because they're jammed full of cases of soda that are going out to rural Alaska.

Dr. McLaughlin, our State Epidemiologist, did a river trip along the Interior of Alaska, and he said, when he went to village stores, that was the thing that stood out most is how much soda was in all these stores for going out there. So I think the evidence is there that this is one of the things that's associated with dental decay in Alaska.

And then in terms of the practice model, if we're trying to lower costs, things that increase efficiency. So in terms of more movement towards group practice where there could be -- you know, in urban areas where you could share administrative expenses, share facility expenses, that would help lower the costs of dental treatment and offer an opportunity for lower fees in terms of doing it.

Expanded function dental assistants, and this is

something that's being used in the tribal program, but it really requires both training of the dental assistant and training of the dentist on how to use that kind of dental assistant. It's been used in the military before. It's been used within the Indian Health Service before, but the idea is you can train someone. You know, so the dentists can come in and give the local anesthesia. That person can get the person all ready. The dentist comes in and does the preparation. That person fills the restoration and then the dentist can come in and check it off. You can do this in a high volume sort of aspect. So individual practice, that might be a tough fit with a solo practitioner, but clearly where you have multiple practitioners, this is a way that you can see more patients at a lower cost.

And then maximizing use of our existing providers, dental hygienists are certainly trained more than what they're allowed to do in most situations. So in terms of -- there is a model in California in terms of the virtual home, and what they're talking about is each provider type practicing to the full extent of their license, that it doesn't need to be the dentist doing everything. The dentist may be coordinating everything, but to make more use of these axillaries.

And then alternative dental providers that Mary is going to cover.

So other things in terms of encouraging our community

health center programs for practice beyond the facility, this is a national effort, but trying to get the community health center programs out into the schools, out into assisted living. Where some of those populations aren't coming to the health centers for treatment, this is a way you can expand services.

The Loan Repayment Direct Incentive Program, in terms of the increase in recruitment in Alaska. The California model is the one that I just mentioned.

Tribal program, increasing capacity. One of the things -- and I don't know that Mary is talking about it today, but I think that, as tribes -- if they can get to the extent that they have the capacity, we need to move back to more routine dental care for Alaska Native adults. With the capacity in the tribal programs, many of them have had to prioritize children, emergent-only for adults. Well, if we're dealing with the disease, the bacteria are typically passed mother care giver to child. So if we're not treating the mom and the mom's got a lot of active decay, that's an aspect that we're weak on in terms of treating early childhood caries. I think it's also a mixed message to be educating a parent about the importance of dental care, but your dental care, it's emergent-only, you know. So I think it's a mixed message, and the national studies show that adults that have access to dental care are more likely to get their kids in for dental

care, and we've got a turnaround in Alaska, too, that, for several generations now, the disease has been high enough that many of our adults are fearful of dentistry. So it's like, in terms of -- they've had heavy-handed dentistry with extractions and everything else. Typically, the way that works as a behavior is you avoid dental care until the next problem occurs. And so we've got to turn that around, that people are getting in for routine visits, and they aren't all painful.

Medicaid. One of the things -- and this was early on, but I am working with the Medicaid program. I want to see us move where our guidance in the Medicaid program now is for a dental visit at age three, earlier if medically necessary. So we will pay for it, if they're earlier. I think, for the education effort, we're at the point now, with more pediatric dentists, this needs to be changed to an age one dental visit, which is the American Academy of Pediatric Standard. It's also the American Academy of Pediatric Dental Standard.

And then payer management aspects, both in the Medicaid program, and I really don't know, within the state employee program, all that's done, but for instance, in the Medicaid program, with the way it's managed now, it's very much within each year. So for example, if we did a restoration on a tooth in year one, and year three, a restoration occurs on that same tooth, there is really no looking at that at all in terms of

what's going on.

Another aspect, in terms of our existing system, some teeth -- for instance, the upper molars -- have a prominent ridge that runs down the middle of the tooth. And so typically on dental, if that ridge isn't undermined, you're not going to cut into it. So instead of doing -- like if the decay is involved in between the teeth, instead of doing one large restoration, you're going to do two smaller restorations. Well, many states now are only going to reimburse that as though it was a restoration for three surfaces because the same amount of time is involved. I mean, you know, you're saving that ridge, but it's really the same restoration. And so in our Medicaid program, that's come up. Well, dentists aren't billing it correctly. They need to be billing that as a three-surface restoration, and no, really, they don't in that, really, what it is, is it's two surface restorations, but by billing it that way, our program is paying a higher rate for two surface restorations than we would for one three-surface restoration. So there are some things in there that are -- you know, they aren't necessarily huge savings, but when you add them all together, there is potential to reduce some of the expenditures, and it still is a fit at what's going on with dentistry, and I think most dentists would not have a lot of heartburn with some of those transitions.

I think I'm about to the end here. So I think that's it. So if there are any questions? Otherwise, I'm going to turn it over to Mary.

CHAIR HURLBURT: Probably, unless there is a burning question, I would suggest we go on to Mary now and then see at the end because we were a little late getting started. We're a little pressed on time.

DR. WILLIARD: If you don't mind, I'm going to stand up a little bit. I just speak better when I stand up. I've got a real soft voice anyway, and this helps me speak a little louder, and I can see you all better.

Thank you all for inviting me to come talk. My name is Mary Williard. I'm a dentist with the Alaska Native Tribal Health Consortium. I run the Dental Health Aide Therapist Educational Program and also am the Director of our new Oral Health Promotion Department, and I'm going to talk to you a little bit about oral health in the tribal health system of Alaska.

A little history. There was a doctor named -- a dentist, Weston Price, went out into Southwestern Alaska back in the 1930s and took a look at the teeth out there. He looked at that area because it was the least affected by outside influences in Alaska. And so what he found when he went out there was that the teeth of the people in Southwest Alaska were some of the healthiest teeth in the world. So he found -

- his findings also coincided with other studies from archaeological sites that show that the cavity rate for indigenous people in Southwest Alaska in that time period is about the highest in the world.

Fast-forward, now, to past the 1940s when we had improved air travel out to rural Alaska and started bringing in a lot of the refined foods and carbohydrates and things. We find that, in 1984, the children in the area in Southwest Alaska had twice the amount of decay of any other area in the United States, so a huge change happening over a relatively short amount of time.

The studies we've seen from the IHS in 1999 and then just recently here in the mid-2000s -- we've had additional studies -- that increase in decay rate has continued to be a problem. Some of our villages are four times the national average.

So tribal Alaska recognized that this increase was something that we needed to deal with, not something that we were willing to allow our populations to suffer from unchecked anymore. So there is a group of really wonderful, energetic people, strong thinkers -- one of them in the room here; you'll see her picture there, but people with the Alaska Native Tribal Health Consortium and the partner, Tribal Health Programs around the state, got together and looked at the issues, looked at the high caries rate. Our pediatric operating room visits in tribal Alaska were skyrocketing, and

those cases are fairly expensive cases, and we do that for kids that are really quite young, between the ages of two to six years old, who can't cooperate in the chair because of their behavior, but also because they have a full mouth of decay, we put them to sleep under general anesthesia to do the treatment and that should be the worst case scenario. Unfortunately, we see this happening way too often, and we believe our children deserve a chance to not have to go through that.

Our vacancies also help contribute to this disease crisis that we're having in rural Alaska where we had -- typically, 25% of our dental positions were vacant in the tribal system and 30% turnover rates on a yearly basis. So when you have that many vacancies and that much of a turnover happening, your dental workforce is very young, inexperienced, and often in the process of training to get better and get ready to be -- when I came out of dental school, I did a residency and learned how to do a lot of this stuff, but most of the dentists we get up here come right out of dental school and have a lot of catching up to do, to be able to do the kinds of services that we need in our tribal programs. So it's an inefficient way to be practicing, utilizing high turnover rates and young dentists.

We also have about 120,000 -- thank you; you guys can hear me better. Hopefully, that's good.

COMMISSIONER ERICKSON: The people on the phone can't hear, unless you're speaking into the mic.

DR. WILLIARD: Great. Thank you. So we have about 120,000 Alaska Native people out in Alaska, and about 85,000 of those are in rural Alaska, about 200 villages, and many of those are not connected by road.

We had some studies done. Brad mentioned a study that was done by the CDC. Here is some information that our ANTHC Department of Environmental Health and Engineering had gathered because a couple of villages had asked about getting water fluoridation going in their communities. So they took a look at what that water fluoridation could do for the communities.

In the first community here, we have 17 of 21 four to six-year olds in that community had undergone operating room dentistry. The average cost for that was over $7,000. So they looked at what they knew about water fluoridation in the communities and felt that, if they were to implement water fluoridation, they could prevent, at least, ten of those a year and that's over $70,000 savings.

I also would like to say that those are villages that didn't have dental health aides in them yet either, and we believe that, if we were able to bring that expanded workforce into those communities as well, we could see many of those children being able to be treated earlier and at home so that

the care would be much less expensive. Worst case scenario for treating a child in the village instead of sending them off to the operating room, if we had to treat 16 of their 20 teeth, would be probably about $2,000. So we really believe that bringing in water fluoridation, when appropriate, and expanding our workforce is going to be a good way to save costs for dental care in rural Alaska.

This is just another village, a larger village, but still a lot of kids going to the operating room. Big savings to be had, if we can address that issue.

So we do have some needs out there in tribal Alaska and in Native health corporations, and some of those needs are -- it's not that we weren't doing prevention services before. It's that our prevention services weren't actually as effective as we needed them to be. So we need to be more effective with our prevention efforts.

We need to be culturally competent, having patients feel like this is a welcoming place to go and get your dental care. We believe having people from the communities educated to provide that service is one of the ways that we can provide more culturally competent care.

We also want to provide basic restorative services. One of the things that people often say is, well, if you just prevent it, then you won't need the restoration services, which is really nice ideology. However, the reality is we

have a lot of existing disease already that needs to have treatment. In order to get patients to come in and see you, you need to meet them where they're at this point. So if we bring a provider in that can only provide education and the patient has a toothache, we're not meeting their needs. So we need to be able to address that need, and then once we have them in and have developed a relationship, we can start doing some meaningful prevention work.

We're also, of course, providing that care locally, cutting down on the travel expenses. If we're meeting our needs intelligently, we will lead to efficiencies is, basically, the bottom line of our what led us to make some changes in what we were doing.

So in the early 2000s, we introduced the Dental Health Aide Initiative, and in that initiative, we introduced four new types of dental providers in rural Alaska. We also -- we have designed these to work as part of the health system, a coordinated effort. The dental health aides are co-located in the health clinics that are out in the villages. They're supervised by a licensed dentist, and we believe, having those providers in those areas, we'll be able to provide more care for the Alaska Native people within the Alaska tribal health system, which would be -- you know, we have the 100% FMAP when our Alaska Native people are seen in our tribal system.

The different types of health aides that we developed

were the Primary Dental Health Aides. Those are our education experts. It's a two-week training module. They can go and work with patients and talk to them about oral hygiene and care at home. They can talk to them about diet and nutrition, help them navigate the system to get the care they need as well.

We have introduced Expanded Function Dental Assistants, as Dr. Whistler talked about, where dental assistants are taught how to place restorations and that can help efficiencies, especially in some of our larger group practices that we have around the state.

And then we have a Dental Health Aide Hygienist. That was because our state regulations didn't allow our hygienists to use local anesthetic when the dentist wasn't in the clinic with them, and when the hygienists were out in a village working without the dentist around, it made it hard for them to provide the care they needed to.

And then last, probably the most controversial aspect of our Dental Health Aide Initiative was the Dental Health Aide Therapist and that's a two-year educational program model in which we select students from out in rural Alaska, bring them in for two years of education. The first year is in Anchorage here and then the second year is out in Bethel. They are full-time students. They learn the basic dental procedures that are needed, learn how to the fillings real well and some

extractions because some of that's going to be needed. They also learn prevention services and then how to refer and manage patients that need care beyond their scope of practice.

So with this new group of dental providers in Alaska, we also shifted how we were looking at dental disease, as Dr. Whistler talked about earlier. When I was out there working -- I worked in Bethel for nine years as a dentist, and I'd go out to the villages every year religiously, and I loved going on my village trips, and I'd work from nine in the morning to 11:00 at night for five days a week as hard as I could. I'd put in the best restorations I could, and I'd come back the next year, and I'd do the same thing. And about three or four years into this, I'm, like, I'm doing this on the same teeth over and over again, and this decay, I'm not doing anything to prevent it. I'm talking to people about brushing. I'm, you know, showing kids, going into the classrooms, but I'm doing it one week a year. So I really wasn't helping to change behaviors in a meaningful way by doing the prevention the way I was.

So we changed our philosophy about how to do this, looked at the evidence out there and found that what we need to do is develop real trusting relationships with our Native patients, and you really have to be around in the community to be able to do that in an effective way.

We need to encourage them to come back to the clinics

regularly, not just once a year when I come in from Bethel to see them, but we need them to be having an ongoing relationship, coming in and getting the services done, treatment done before cavities get so big that the only option is to take a tooth out.

And then also if we are able to build these relationships and trust, then hopefully, we'll be able to overcome the fear and avoidance that has been the outcome of providing episodic dental care in the villages. So basically, we wanted to look at the reality that we need to pay more attention to the people in the community than just the teeth.

And as part of our Dental Health Aide Program, what we've come up with as well is a program that I call the Healing the Healer program. Our students that come in from these high risk dental areas are living in -- are from also areas that are high risk for other things and have other issues, social issues. Their educational programs may be less than optimal. We may have other domestic violence/sexual assault issues that they will encounter in their lives there or the patients in their chair will have encountered. And so they need to know how to manage all of that in a holistic view of health for themselves and for their patients. And what we've really come to understand is that investing in these young people is more than just fixing teeth. It's actually providing a role model for the communities. Somebody from their own families has

come in, got the education, and come back home and is able to provide an economic engine for their own communities as well as a good role model for healthy behaviors.

And we're doing this all within a dentist lead team, which is part of an integrated medical system where we have the dental health aides and the community health aides and other village-based providers working together in the medical clinics in a hub-and-spoke model.

So how are doing? You know, the theory sounded great when we brought it up. That's why I jumped onboard. I thought, wow, this sounds awesome. I was real surprised when people didn't think it was a good idea. So, we're, like, well, we should take a good look at what we're doing, do some studies. We've had some studies done. They're preliminary studies with somewhat small numbers, but the numbers are very promising. They're showing that our patients are receiving more care. They're satisfied with their care. It's the same quality of care that our dentists were providing in our tribal health system. And when you look at those small numbers and compare them to the numbers internationally that have been done on dental therapy and other alternative workforce models, they coincide very well. So the strength of our numbers gets even stronger when you look in the light of international data.

But we did look -- recently, I had a health economist

come in and take a look for me at things, and she -- Mary Kate Scott was her name, and she's from Scott and Co. Consulting, and she surveyed all of the dental programs, all 11 that were utilizing dental health aide therapists at the time and got surprisingly 100% compliance on the surveys. We were thrilled that everybody was able to send us back information. And what we found was that that information was -- not only did everybody reply, but everybody had very similar information. So we felt it was -- even though we allowed them to estimate the data on the cost and things, the data felt very strong because all of their responses were similar.

So on average, a DHAT team, which would be the DHAT and their dental assistant, sees about 180 different patients in about 1,200 patient encounters per year. Of those encounters, 700 of them are preventive services.

We have encouraged the dental health aides to put down their hand pieces or their hand instruments and provide community education on healthy behaviors in dental care, and what we're seeing is that that's actually being done in their practice. We're seeing, at least, one to four hours a month being put into community education services.

And the tribal investment on this -- tribal sponsors of the students pay $70,000 about in tuition. Within the first eight to 12 months of that DHAT graduating and going out and working, the tribal program has recouped the cost of their

investment by the services they're able to bill from that dental health aide therapist. That does largely rely on the State Medicaid encounter rate to make that possible, so we're glad to have that.

The tribal revenue reported by the dental directors, net cost after we -- or the net revenue after we take away the salaries and the costs of the assistant and travel, benefits, supplies, and other costs was a net generated income for the tribes of between $120,000 to $245,000. So it's an economic advantage for the tribal programs to have these lower cost providers providing care out in the communities where the dentists are not able to get to. And in that, we had a $40,000 avoided travel cost for each of these teams, which is great and can translate into less cost for Medicaid travel.

COMMISSIONER CAMPBELL: You talk about the fees generated. Now, what kind of a fee schedule are they using, a full dentist as if the dentist was billing or some lesser fee?

DR. WILLIARD: Yes. They receive the same -- Alaska Medicaid has agreed to pay for dental therapist or dental health aide services at the same rate that a dentist would bill for, and when you look at that, as Dr. Whistler was saying, Medicaid pays about 70% of what a dentist would normally charge of what the cost would be. So to decrease the amount that you would pay for the dental health aide therapist doesn't really help make that a very economic model because of

the way that we pay Medicaid.

And then so also, our community engine that we're seeing happen through the community health aide -- the Dental Health Aide Program is, at that time, we had 19 DHATs. They generate somewhere around 76 jobs within the state, including their assistants, the training program, management, and staff. Over half of those jobs are in rural Alaska with a related $9 million economic activity to those jobs.

They improved access. There are over 40,000 people now that have that direct access to a dental provider that didn't have it before through these providers, through the dental health aide therapists specifically.

We have 58 new providers in the state for dental, and they're living and working where dentists weren't before. That's improving our quality of care for patients, allowing us to do more effective prevention work.

We've had four students -- four classes graduate in our two-year post-high school program here. We have two more in the pipeline, one graduating in June. And then we're recruiting for our seventh class.

Our dental therapists are part of a national organization, the American Academy of Dental Therapy, which they started, which includes therapists from Minnesota. This model is spreading. Minnesota is the first state, outside of -- well, the first state that has changed their Practice Act

to allow dental therapy. It was a grass roots campaign, and there was a fight, like we've had, with organized dentistry about it. And so there was a lot of compromise that happened. They have two different models in their state, Dental Therapist, either Bachelor's or Master's degree, and then they have Advanced Dental Therapy, which requires a hygiene degree prior to it, and it's a Master's level.

Nationally, over 20 states are looking at this very seriously, getting ready to put in legislation to expand their workforce to include dental therapists. This is going to be a continued struggle. I imagine we'll have about 50 different types of dental therapists in the U.S. once all the dust settles, and it will take a few years for us to figure out how we really want to practice with this, and what we'll see is what see with the PAs in the medical profession where, pretty much now nationally, we know what a PA does. They do pretty much similar things throughout the states, and it's very well accepted.

Let's see here. The federal actions that are going to be affecting us and our ability to continue to provide care. The sequestration, of course, you know about. These you guys know better than I do, so I'm not going to spend a lot of time talking to you all about that.

We are concerned about the sustainability of our programs. We think they're great programs. We think they

should be funded and funded well. However, Indian Health Service is funding at about 50% to 60%, the level they need.

Some of the issues we have, besides just the dental workforce, is the Alaska sanitation, which is, again, underfunded. A quarter of our Native homes don't have adequate sanitation facilities. The downward trend is in funding those. Having drinkable water would allow us to help fight the bottle against the sugar sweetened beverages. And also if we had adequate water and sanitation, we would be able to provide community water fluoridation as well.

So cost containment that we see and areas that we've tried to address and are still continuing to try are delivering care close to home, cutting out the travel costs, alternative workforce models that can get out there and provide the care in new and different ways and different settings, effective prevention instead of just more prevention that doesn't work. We're going to do community water improvements, including, hopefully, fluoride and decreased sugar sweetened beverages, and recruitment and retention of dental providers for less turnover and more skilled and experienced practitioners, and then decreasing our OR visits.

So finally, that's my contact information. If you have more questions, happy to talk to you. Look us up on Facebook, ANTHCsmile, and thank you very much.

CHAIR HURLBURT: Thank you, Mary and Brad, very much. I

think we'll have some time for a discussion, and we'll start with Bob, but let me maybe offer an observation and not a question. And you've pointed out to me, Mary, that the dental technicians actually receive closer monitoring of the quality of their work than dentists do because of the every two-year requirement for hands-on supervision and looking and seeing what they're doing and that you've clearly demonstrated this as an appropriate model delivering high quality care.

In the medical model and with our American penchant to professionalize, we've seen physician assistants generally with a background of being a medic in the military, but starting out with one-year programs and two-year programs and now four-year programs, and nurse practitioners starting out as nurses and receiving a Master's level of training, and now the requirement by the Nurse Practitioners Association that, in 2019, they will require a doctor's degree. It's going to -- and where, again, it's clearly been demonstrated that, for many issues, most patients have a more satisfactory encounter with a PA or a nurse practitioner than they do with a doc, partly because they're more interested than the docs, working to the highest level of their training, partly because they have not been as expensive and they can spend more time dealing with it.

So it's a comment, but with you as being the godmother of this concept that's now spreading nationally, how do you see

taking that into consideration as to what may be down the road, where you've developed a model that meets a need, that can help contain costs, that can help improve overall quality, but then dealing with our American penchant, in the name of doing better, to always professionalize more and more and more?

DR. WILLIARD: Well, that's a lot of the struggle that we're having around the country right now with dental therapy, many people saying that these providers won't be respected unless they have a Bachelor's degree because that's expected in the United States these days. And what I keep bringing it back it back to is it's great to have education, and you know, we first started out where education was a luxury, and the people -- the common people couldn't access it, and what we need is education that's enough, enough to do the best job you can and the appropriate job, and if we continue to require additional years of education, we are going to become, again, a nation of elite educated people, and the common people aren't going to have access to that, you know. What I hear from my students, if this was a four-year degree, they would not be in my program. They have a hard enough time coming into Anchorage for one year. Unfortunately, we send them back out to Bethel for the second year. And often, they're the first students in their -- the first people in their families that have gone on to anything beyond high school education.

This is an opportunity that's achievable, attainable, and realistic in their own minds. And you know, once they get here and complete this, maybe they'll go on and do some more. That's great. That's not my goal, of course. I want them out there working as dental therapists, but you know, this is attainable. It's definitely enough education to do an excellent job as a dental therapist, and you know, I just hope people can stand up against that kind of push to overeducate that we have happening here.

CHAIR HURLBURT: Thank you. Bob?

COMMISSIONER URATA: I have one comment and a question for Brad -- or for Dr. Whistler. I have a solution for your record keeping. It's called Electronic Dental Records, and you can join the Health Information Exchange that we're dealing with right now. That's more of a joke.

So on a more serious note, have you been keeping records of the dental status of children in Juneau since they've removed fluoride, and if you have, can you comment on that?

DR. WHISTLER: Sure. Anecdotally, public health nursing in Juneau has reported that they think they're seeing more dental decay in young children. As far as sort of a study approach in Juneau, if you were looking at changes in water fluoridation, what you're looking at is wanting to know, at the tooth level, what was going on in Juneau, when they were fluoridating, and then track that over time. The only

information we have that's like that in Alaska has been some point-in-time studies that were done by the Indian Health Service. So we pretty much lack data, at that level, for any community.

So as a fallback position, what we're doing now is we're going to take a look at the Medicaid claims information to see if we can document if there are more dental procedures related to dental decay in Juneau, as it went from being fluoridated, and the part in Juneau is Juneau -- we're looking at 2009 -- or let's see -- 1999 and 2000 where Juneau was optimally fluoridated. From the year 2001 to 2007 when they went off fluoridation, Juneau was never optimally fluoridated. There was resistance to fluoridation in that community that was occurring before they went off fluoridation. So there will be a transition period where, in some of those years, there were months that they weren't fluoridating or they were fluoridating below the level that was recommended. So then we'll see what happened during that transition time, and then in January 2007 where they went off, then look at that period forward and see if we can document anything. The problem with that, I can't assure that we're going to see information that's really useful there. There are studies that have been done like that on statewide populations in other states, but in Juneau, we're looking at a much smaller population than we would be on statewide populations, where this was done in

Louisiana and New York, and the other part is we're not even looking at the whole population in Juneau. We're only looking at children enrolled in Medicaid, and under that, we're only looking at children enrolled in Medicaid that got a dental service. So we're looking at maybe half of the children that were enrolled in Juneau in Medicaid to see if we can find something. So I can't assure that we're going to be able to do that, but we are taking a look at it.

COMMISSIONER URATA: You know, I think one of the concerns -- while we were campaigning to keep fluoride in Juneau, one of the things is we didn't have strong data or information to campaign with, and I think one of the things that we were concerned about is that we would see more dental caries among our children and more surgeries to remove teeth in our children and such, but it's a multi-factorial issue.

So are you planning to monitor the situation in Fairbanks, for example, who has stopped fluoride, you know, to see -- to try to get some sort of data on really what happens? I think that would be valuable from a public health perspective for the future of fluoridation in our state.

DR. WHISTLER: Just a comment. I think that one of the things that we faced in Juneau was not that there wasn't any information. There is national information on this, but there is not for the state of Alaska. And from funding agencies that do this, because we rely on federal grants, there is not

lots of those federal grants because it's already a demonstrated issue. So there are not federal grants out there for each state to repeat studies that have already shown that kind of reduction.

So in terms of looking at the kind of study where, if we went into Fairbanks and we took a random sample of children and scored their dental decay, you're looking at dentists doing, basically, dental examinations on all of those children and then doing that longitudinally each year. Those are, like, million dollar studies to do that kind of study design. And so that's why we're falling back to see if we can look at Medicaid.

So at the same that we're looking at the Medicaid claims data for Juneau, we're going to look at, you know, trying to get baseline for Fairbanks to see if we can monitor that over the time. Same thing with Palmer that went off. We're also going to try and see if we can demonstrate any differences. Like, for instance, in Southeast, Sitka and Petersburg have been longtime, optimally-fluoridated systems, and compare Sitka and Petersburg with Wrangell and Ketchikan that have never been fluoridated -- and they're similar demographics; they're in the same region in the state -- to see if we can demonstrate. So the power isn't really that we expect to find something new. Our problem is it's smaller numbers, so we're not sure it's going to be useful, but there still is value,

from a policy standpoint, to have information from your community or from your state that repeats the same thing that was found in national studies. So we're going to see if we can get anything out of the Medicaid information, but I can't assure you that we're going to.

CHAIR HURLBURT: And CDC, the Arctic Investigations program here, and you know, Brad and the tribal health system have all been involved in these discussions of what is the potential for looking at it. Fairbanks offers some advantage in that it was a well-operating system that, boom, shut off, and it didn't kind of trickle off the way Juneau did, but there very much is a desire to get at that, to not only help today but to help the future.

Anchorage was one of the early cities in the country to go fluoridated. Anchorage adopted fluoridation in 1953 and was pretty forward-looking, but now, we're the red lantern state. We're -- I don't know that we absolutely are, but we're about 55%, and nationally, we're probably just a little over 75% now of folks being advantaged by being exposed to fluoride and water systems.

DR. WHISTLER: And I'll just echo what Dr. Hurlburt said because it's kind of like, in Alaska, there is sort of this feeling like, well, a lot of places are doing this, and it's coming up for a lot of votes. It tends to be in communities that are about the size we have here in Alaska. They don't

have -- you know, they don't have health departments or sort of the infrastructure in place to really survive, if opponents kind of wage a war on water fluoridation, but nationally, most major cities now are fluoridated. And so San Diego is now fluoridated. That was the most recent one to completely fluoridate. San Jose is in process. Portland voted to fluoridate. Of course, Portland had had a lot of opponents, and this was their fourth round going for water fluoridation in Portland, Oregon, and the health board passed fluoridation, but now there is a public initiative. But Portland would now be the next largest U.S. city without fluoridation, if they don't move forward with water fluoridation. So we are over 75% of the U.S. population on public water supplies that have optimally-fluoridated water at this point.

COMMISSIONER ERICKSON: Brad, just a quick question and then Val had a question or a comment. I was just wondering, you had mentioned being able to access the Retirement and Benefits Employee Health Plan claims data. So when you're looking at the Medicaid claims data, do you have an opportunity to make inquiry and the same question to some other -- some of the dental plan carriers to see if you can get the same sort of information from them?

DR. WHISTLER: Well, just to sort of restate, I have more routine access to the Medicaid claims. What we did -- there was sort of this discussion in terms of, was the fee structure

of what was reported by dental providers, what they were billing, was that truly what they were billing or were many providers billing the Medicaid rate, so that our fee profiles in that system were artificially low? And so we ended up with, through an agreement with talking with Retirement and Benefits, a one-time project to look at common dental procedures and see how those compared, and what we saw was the average dental fee billed to Retirement and Benefits was very similar to what it was in Medicaid, which sort of reinforced that our Medicaid reimbursement rates are in that general 70% to 80% of the mean charge for dental services in Alaska, but there's not -- it's not routine access in terms of looking.

And the other point that I touched on was this same thing. In the course of talking with Retirement and Benefits, it just made me curious in terms of what sort of edits and stuff they're doing in the dental claims system.

I'll give another example. Dental sealants are very effective on permanent first molars, but some of them come off. So it's not like you'd only want to pay for it once. On the other hand, if you were paying for a dental sealant on the same tooth every single year, you would start to question if that was cost-effective or not, and it also might point you in the direction that, if it's coming off a whole lot, maybe that provider is not doing a great procedure there, that you might want to check in on that. We don't do anything like that kind

of management in the Medicaid program at that level, at this time, and I also suspect that we don't do that in the State Employee Health Insurance System. So I think there are things that you could look in there in terms of, what's a reasonable amount of how many times we want to pay for the same service on the same tooth because even fillings fail, even gold crowns fail eventually, but you certainly wouldn't want to be paying for a gold crown one year, and two years later, be paying for that gold crown again on the same tooth, and I just -- I think that's sort of the direction that we need to start looking at is multi-years for similar procedures on the same tooth, or at least, at the same provider, if it's the same provider that's billing for that code again, to be looking at that, just a little bit of oversight in terms of doing it. So that was my point.

COMMISSIONER DAVIDSON: Dr. Williard, can you talk a little bit about the certification process for dental health aide therapists and also the recertification and what's required for a DHAT to be recertified and how that recertification differs from a practicing dentist?

DR. WILLIARD: Yeah (affirmative). Sure. So in our health aide system, we have certification through our Community Health Aide Certification Board and that's a federally-recognized board. And to become a dental health aide, you have to meet all the requirements in our Community

Health Aide Standards and that includes the education requirements. And so once you finish your education requirements, then you have to do a preceptorship, which is -- you might consider it a mini-residency of a sort where you work side-by-side with your supervising provider. That allows both the dental health aide and the supervisor to get to know each other and their strengths and how they practice. And then once that's completed, then they can apply for certification.

Certification then requires that, in two years, you apply for a recertification, and within that time, there is a continuing education component, which matches the -- for the dental health aides, it matches the requirements that dentists have in this state for continuing education. And then beyond that, they also are required to work side-by-side under direct supervision of their dental supervisor doing every procedure within their scope of practice. So they have to work, at least, 80 hours under direct supervision in that two years with their supervising dentist.

So we have what's actually a continual competency evaluation happening within the Community Health Aide Program where each provider is directly observed providing care throughout their career and that's the epitome of what most places are aiming for when you're talking about provider competency and continual competency.

Whereas, me, as a licensed dentist here in Alaska, I applied, got my license, and every two years, I pay some money, and I go and attend a couple of continuing ed courses and learn some new things and that's good to go, and nobody ever has to look at my work again throughout my career, and I can continue to practice. Typically, the only time a dentist gets their work looked at again is if somebody has filed a complaint with the Board of Dentistry.

So you know, I feel very comfortable with the care that our dental therapists are providing. I have my children go see the dental therapists, and it's -- you know, they're very well supervised, very well managed as far as being a provider in a career and working to improve constantly.

COMMISSIONER PUCKETT: Did I hear correctly that they go -- one year, they go to a school outside of where they live?

DR. WILLIARD: Our program for dental health aide therapists is a two-year, post-high school educational program. So the first year is located here in Anchorage, and that year, we do a lot of the didactic work, book learning and working on mannequins as well for the fine motor. And then the second year, we send them out to Bethel, and that year, that's a much more clinical year where they're seeing patients most of the day.

COMMISSIONER PUCKETT: Do you have a good retention experience with students, that they enroll and then actually

do finish?

DR. WILLIARD: We have about a 64% retention rate of our students that have enrolled, which is on average with -- or actually better than universities. And then the retention rate of our dental therapists working in the communities, we've had 31 therapists that have graduated from a dental therapy program and started working, and we still have 25 of those working after nine years.

CHAIR HURLBURT: Any other questions or comments? Brad, yes?

DR. WHISTLER: Just one thing I'll mention in relation to a question that Mr. Campbell asked earlier is, the other thing traditionally in dentistry is the dental claim form lists the billing dentist and the treating dentist. So even in private practice, typically for procedures that are done by the dental hygienist, it's billed for by the dentist, and it's billed the same reimbursement rate. So that's been common in dentistry, that there really hasn't been a separation of rates, even between the dental hygienist and the dentist, traditionally, in dental practice.

CHAIR HURLBURT: Thank you both very much for coming. This was very helpful, and thank you for your preparation and your presentations.

DR. WILLIARD: Thank you.

CHAIR HURLBURT: We'll take a break and come back

together at 11:15.

10:59:30

(Off record)

(On record)

11:12:24

COMMISSIONER ERICKSON: We're reconvening. For those of you on the phone, we've switched our last two agenda items, and we're going to start now with the Federal Health Care Reform Update. And for Commission members, you should have, in your notebooks, our PowerPoint presentation that I've been using for a couple years now with -- just update every quarter to provide information on implementation activities since the last meeting, and you have that in your notebook behind tab five. I'm going to just, real quickly, go through the first four slides, which are bullet points on some of the significant activities of the past three months since our last meeting and then turn it over to Josh and Commissioner Streur to share a little more information with you and answer any questions that you might have.

So a couple points real quick. The Fiscal Cliff deal that passed on January 1st, there was one significant impact to the Affordable Care Act in terms of financing and that was the elimination of available funding for the Insurance Co-Op program. There was $1.7 billion left in that program; 1.9 had been allocated and awarded in low interest loans to 24

different programs that would create these co-op programs in 24 different states.

And in addition to that, the Community Living Assistance & Support program, the CLASS Act, that was intended to be a new national long-term care insurance program, that was eliminated and replaced with a Commission that's charged with developing a national long-term care plan by this August.

And then following that, the sequester that took effect just a few days ago, cutting $85 billion in federal spending for this current federal fiscal year, there are impacts directly to a number of Affordable Care programs, including the Insurance Exchange's Prevention & Public Health Fund and the Small Business Health Insurance Tax Credit, but also significant impacts to other health programs. Just a note that Medicaid is exempt from the sequester.

I was just mentioning the Insurance Co-Ops. I won't go over that again, but of note related to that -- and I haven't had an opportunity -- I want to follow-up with the folks who I heard interviewed who had participated, apparently, and I heard -- I made a footnote that this bullet is about -- was from a story on APRN, on Alaska Public Radio Network, but apparently, there were a group of individuals who were working on creating a multi-state co-op that's a Consumer Operated Insurance Plan and had just, on December 31st, submitted an application for funding from that program, but that program

then, the following day was -- the available funding was eliminated in the Fiscal Cliff deal, so just to note a potential, specific Alaska impact. Yes, Val?

COMMISSIONER DAVIDSON: So Deb, I just wanted to make a clarification on slide two, health impacts. Indian Health, we were not limited to a 2% cut. We, actually, were subject to a 5% across-the-board cut, just like other health programs.

COMMISSIONER ERICKSON: Yeah (affirmative). I wanted to check on that. I was -- so thank you for that clarification. I'll correct that.

COMMISSIONER DAVIDSON: Yeah (affirmative). I think, in the original justification on the Senate side, it mistakenly said 2%, and we all celebrated, and then, unfortunately, they came back and corrected and said no, 5%.

COMMISSIONER ERICKSON: And said oh, never mind. Thanks for that clarification. I'll correct that on the version that's posted on the website.

Related to the High Risk Pool, the Pre-Existing Conditions Insurance Plan, there was $5 billion appropriated for that program. It was intended to continue through the end of this calendar year to provide a bridge to January 1, 2014 for folks with pre-existing conditions who could not otherwise obtain insurance, but that program has, essentially, run out of money at this point. And so the federal plan stopped accepting new enrollee applications on February 16th, and the

state-administered programs -- and Alaska has a state-administered program through ACHIA -- were directed by the federal government to suspend acceptance of new enrollee applications; is that not correct?

COMMISSIONER DAVIS: The Pre-Existing Condition Insurance Pools have -- and new applications are discontinued, but the State ACHIA plan is continuing on, unaffected.

COMMISSIONER ERICKSON: Well, so what I need to do is clarify it. It's the federally funded under.....

COMMISSIONER DAVIS: It's a federally funded PCIP that's administered by ACHIA.

COMMISSIONER ERICKSON: Exactly. Exactly.

COMMISSIONER DAVIS: That's suspended, but the State ACHIA continues on, unchanged.

COMMISSIONER ERICKSON: And that's what I meant to write here and what I meant to say. Do you think.....

COMMISSIONER DAVIS: Well, what you said I heard differently, but -- so perhaps, there is confusion.

COMMISSIONER ERICKSON: Right. Okay. So the state run Pre-Existing Conditions Insurance Plan created under the Affordable Care Act, which includes Alaska's state run Pre-Existing -- Affordable Care Act supported -- ACHIA has, essentially, two different plans that they're administering, two different, high risk.....

COMMISSIONER DAVIS: The federal and the state. That's

the way it's distinguished.

COMMISSIONER ERICKSON: One's the federal, and one's the state?

COMMISSIONER DAVIS: Right. The federal has been suspended.

COMMISSIONER ERICKSON: The state program is continuing?

COMMISSIONER DAVIS: Correct.

COMMISSIONER ERICKSON: But the state-administered, by ACHIA, federal program funded under the Affordable Care Act is discontinuing?

COMMISSIONER DAVIS: Yes.

COMMISSIONER ERICKSON: So I'll rewrite that bullet to make sure that that is really, really clear.

COMMISSIONER DAVIS: Thank you.

COMMISSIONER ERICKSON: Thank you. Related to the Insurance Exchange and the Medicaid expansion, Josh and Commissioner Streur will comment on this further here in a minute. I've just noted that, on February 15th, it was the deadline for states to file their blueprint with the federal government, if they were intending to partner with the federal government on a State-Federal Partnership Exchange. Seven states opted to do that. Right now, 17 states are planning to operate their own exchange, and 26 states, including Alaska, plan to participate in the federally-facilitated exchange.

And I just included a note there -- we talked about this

yesterday a little bit -- that our new Eligibility Information System that will be underway here shortly, the process to implement it. The first phase is intended to be compliant with the Insurance Exchange requirements by October.

And then I just posted here the Medicaid expansion decisions as of just a few days ago, that, so far, 26 states, plus Washington D.C., have announced that they will expand in 2014. Seventeen states, including Alaska, have announced that they won't, and seven states are still weighing their options.

And I am not going to go over this very detailed list. I'm on slide five, for those of you who might be following along on the phone. But on slide five, I've just listed, with the date, all of the final and proposed regulations and the guidance documents that have been released since our last meeting in early December. And with that, I'm going to turn over the mics to Josh.

MR. APPLEBEE: Well, thank you. It's great to be here again to kind of bring you, and all the Commission, up-to-speed a little bit on -- I'm going to first talk about the Health Insurance Exchange, the Health Insurance Marketplace, as they are beginning to try to rebrand it. And I know that she had the slide up there of all the additional regulations and things that have been flowing out.

Our Division of Insurance has certainly been thrown into the weeds when it comes to the Insurance Exchange. I mean, a

lot of proposed rules, final rules, draft letters, interim final rules have kind of been coming down the pike in anticipation of being ready for enrollment in October of this year, but more importantly, to try and lay the groundwork so that companies, like Premera, can then begin to develop and file their rates for any insurance product that's going to be offered in the Exchange going into the next year.

And so, you know, in my past updates and in other presentations to other groups, I've always mentioned that, you know, we don't know what the Exchange is going to look like. We don't know how it's going to feel. We don't know what kind of interface it's going to have for the consumer, but I always say that there are these rules that are coming down, and you know, they're centered around enrollment, health insurance provider fees, and I have this whole list, whether it be the Small Business Health Option Program, what we call the SHOP, final notice on benefit and payment parameters, multi-state plans, letters to issuers, notice of benefit and payment parameters. These are all kind of real granular items that Jeff Davis and his group and all of the other insurance providers need to develop what they're going to provide to the State.

But in terms of, you know, what the interface is going to look like, and more importantly, how we're going to get the word out to Alaskans about the Exchange and things like the

Navigator program, what form that's going to take, what sort of approval process is going to happen with that, what -- you know, when you talk about the 800 phone number, which is going to be really important in our state, and language services and these sort of issues, we continue to press CMS and CCIIO and the people developing it that we want to be part of that conversation. We're more than willing to allow them to take our time and to tell them where our challenges are going to be, where our needs are going to be, and I wouldn't say that they haven't received those notices because we've been very clear and very up front about it. I just don't know if they're at that point of development yet. They're trying to get everything they can for the insurance companies to do the work that they need to do in the short timeframe that they have. They have their tech people developing, you know, the interface, the Federal Data Services Hub, all of that stuff that's going to be working in the background. I think they're saving the front end stuff for last, and for better or worse, that's the path that's they've taken. And as soon as they begin to engage us in those conversations, I think we'll be right there at the table to tell them, you know, about the unique needs of Alaska and what we need them to consider when they're doing that development.

But suffice it to say -- and I rather feel sorry for our Division Director, Bret Kolb. His updates, much like Deb's,

are getting longer and longer every time the federal government sends a new email. But CMS and CCIIO have scheduled -- well, have requested a meeting with the Division of Insurance, and I hope to be a part of this further discussion as things go down, and I know, in our latest update, that he's looking to set up a call with CMS in the next couple weeks. So hopefully, we can reiterate again our desire to be at the table to let them know what needs to happen when it comes to the Insurance Exchange interfacing with Alaskans and how that moves forward.

Well, and I guess, really in summary, everything that's happened since the last time I talked to you has been real boring, dry stuff. Necessary, important, boring, dry stuff.

In regards to Medicaid expansion, the Governor, in a press conference on the 28th of February -- I'm sure many of you have followed the news -- came back from Washington D.C. with several concerns about how the government is handling its business, but specifically in regards to Medicaid expansion, he, unlike the slide -- I guess I would probably -- as long as you're making changes to slides, Deb, I don't say that -- I wouldn't say that we're a "no" when it comes to Medicaid expansion, when you have states that are expanding, states that said no, some are still weighing the options. I think that we're actually still weighing our options and that the Governor was very clear that his next decision point isn't

going to come until December when he submits his budget for next year, and I think that was a pretty powerful statement because, if you remember the last time that the Commissioner and I were in front of you and several times since then, he has been very clear about wanting to get this decision right and not making a quick decision, one way or the other, but analyzing all aspects of it.

And the Governor also spoke of working with Secretary Sebelius and HHS in terms of flexibility, and I think that really gets to what other states are doing and other states' conversations with the Secretary. You know, you talk about states like Florida and Ohio. The Governor of Florida says we're going to expand Medicaid and then the Legislature needs to make the decision three years later.

But let me talk about Arkansas, and I don't know if many of you have followed the news that came out of Arkansas two weeks ago. The Governor of Arkansas, Governor Beebe, had a conversation with Secretary Sebelius, and they came to a verbal agreement that Arkansas will be allowed to move all of their Medicaid recipients to the Exchange, all of them. Now, he doesn't have anything in writing yet. He's still working out some of the details, and we are very excited to learn about some of these details, but if that sort of flexibility is an option, if that's the sort of ideas that CMS may be considering, then this analysis, I think, becomes much more

complicated, much more involved. So I think I'm more excited about the possibility of that flexibility that the Governor talked about, and you know, being able to look at what's really possible as opposed to black and white, it's this way or no way sort of thing.

I looked at a chart of the 15 states with the highest uninsured residents, and of course, Texas tops the list at 24%, down to Wyoming at 18%. Now this is 15 states. Seven states said that they're going to expand Medicaid. That includes Arkansas, and I think that might need an asterisk because I think they have said they're going to expand if they get this option, and we'll work that out down the road.

Six say they are not expanding, and two are undecided. And of course, we're in the undecided column. So it really is a state-by-state decision, and I think, certainly -- and I don't want to put words in the Commissioner's mouth, but I will say that we're very focused on making the right decision for Alaska, regardless what other states do, but if the Secretary is going to allow other states to have a level of flexibility, I don't think that you'll see us just sitting on the sidelines. I think we'd want to get in those rings and fight for that level of flexibility as well.

So that's been the development since the last time that we've met. There is, I think, a lot of analysis still left to do. I think it's still not a very clear cut decision. I

think it's certainly not a no-brainer, as it's been characterized by some people. I think it's one that our Department takes very serious. I think it's one the Governor takes very serious, and as we move forward, I think we'll maintain that level of looking at it like the serious decision that it is.

COMMISSIONER STREUR: Josh says he doesn't want to put words in my mouth, but you know, frequently when we're both down in Juneau walking the hallowed halls, he's had to say "what the Commissioner really meant to say was" and that's why I take him along with me. Representative Keller, you're well aware of that, so anyway.

You know, on top of the Medicaid expansion, I think that the boss, the Governor, is really taking the right direction on this, that, you know, we've got time. Let's do it right. Let's figure out who blinks. And one of the things that we're seeing increasingly is a willingness to blink on the part of the federal government. And if Governor Beebe's process goes through, to me, it's a very innovative, minimal risk approach for the State of Alaska. It doesn't mean that I'm going to recommend it. It doesn't mean that he's going to go along with the recommendation, even if I do. It means that there is more opportunity out there because that was the first concept that I floated over two years ago back in Washington D.C. with CMS, and they wouldn't give me an answer.

So what I had proposed was a little different than what Governor Beebe is proposing, but the same concept was there, and I understand Wisconsin has moved forward with something very similar to what we have proposed. So that aside, Medicaid expansion, stay tuned because I truly believe we are undecided as well.

The thing, for me, that's a real challenge -- and Jeff may want to weigh in on this -- I do not see how the federal government is going to bring up a federally-facilitated exchange in 20-some states -- I believe 26 to 29, depending on the day of the week, in the next six months and that's technically what has to happen. A federally-facilitated exchange isn't something that you just plan in the state and say, okay, turn the switch on because you've got to implement and integrate the insurance regulations of that state, the insurance plans of that state, the different levels of plans that are going to be available. They have to -- I haven't seen the federal plan yet. Have you, Jeff? And you know, all those things have to happen in the next six months. And you know, you can say six months is a long time. You know, having worked with technology for the last 20 years, six months in the technology world is, you know, a blink of the eye, and MMIS is a good example of that.

So the key to the Medicaid expansion for states is the Exchange. The key to many aspects of the Affordable Care Act

in terms of expanding coverage is the Exchange, and we're not there, and I don't see how we're going to be there in 180 days because we were on a call this morning with the Governor's Office and the Division of Insurance, and there were almost as many questions as there were -- they weren't answers; they were concepts that were brought out because we don't have any answers yet. And you remember, you know, the standard answers that Josh and I were getting, "soon," "later this summer," and "we'll get back to you." There is one more; I forgot it. But anyway, those are starting to emerge again, so it's going to be interesting.

So Josh also talked about, you know, the Feds are focusing on the Exchange at the federal level, and the states are going to be next. One thing that's become abundantly clear is that the Feds' implementation of the Exchange and multi-tasking do not go in the same hand. Just, everything seems to be a separate, distinct we'll get this done and then we'll start looking at this. We'll get this done, then we'll start looking at that.

So I said it a couple months ago, and I'm saying it again. I'm really skeptical. You know, I'll just retire if I'm wrong, but -- so I don't have to come back. But anyway, I'm really skeptical about the Exchange going live, and stay tuned on it because it's going to come up in the next few weeks, and there is a lot to do for the Affordable Care Act to

go live in Alaska, and I look at all the boulders, if you will, that we have to get past. The deeper we -- the closer we get the more boulders that seem to arise. So with that, I say press on. Thank you. Questions? Emily? Oh, I guess I'm not supposed to do that.

COMMISSIONER ENNIS: Thank you. Would you mind just taking a moment and giving an example of a few of those boulders that have come up recently?

COMMISSIONER STREUR: One of them is the Exchange itself. You know, we've been promised a straw man, a model of what it was going to look like since November, and the last time I was in front of you I talked about having spoken to CGI, the prime contractor, and they weren't ready to release it yet. We still haven't seen it. That, to me, is a big one.

Coming up with how many players there is going to be in the insurance market in the Exchange world in Alaska. You know, is Blue Cross -- Premera Blue Cross even going to be at the table with regards to the Exchange because, if they're forced to bring bronze, silver, gold, platinum plans for, you know, this relatively small population base, I'm not an actuary, but it's not something I'd want to take on, even with the little bit of understanding I have regarding it. Those are two of the big ones.

COMMISSIONER MORGAN: I mean, I'm sure it wasn't -- I think the Supreme Court decision that made it optional for

states to make their choice kind of precluded or shocked the federal officials involved in this. They just assumed that this would be -- that we'd all hook. But it came up yesterday, and I've been thinking about it for a couple of weeks that, if you -- and I understand and have always understood, because I actually watched the Governor's press conference, that it was a, hey, I need to think about this and look at this and actually maybe see some of it enacted. You know, it's one thing to talk about this stuff this way, but to actually see it happen in Arkansas or somewhere is a whole different world.

But one thing that seems to be an anomaly that has come up -- and this was talked about two-and-a-half weeks ago when I was in Juneau -- is, if you don't expand, since the whole goal of this is to give people coverage, there is one group, between zero and 100% of the poverty level, that cannot access the Exchange and obtain the same subsidies and tax credits as someone that 101%, which is a little silly, if you think about it. So I would hope that, when you're discussing it with your fellow Commissioners of Health and Human Services and other leadership that way on the state level, that's -- I would think is just a regulation, since they're promulgating, evidently, thousands of them to do that because some states may, probably if there is no flexibility, not do it. I mean, it's a rational decision for each state to make, but if our

goal -- if all of our goal is to get everyone covered, let's not build into the regulation to absolutely make sure that that zero to 100% is faced either paying a tax or somehow coming up with the money, which we know they can't, to pay for health insurance because this guy over here is saying it's going to go up 21% to 70% under this deal. I'm trying to figure out if I'm going to be able to afford health insurance, if that's true. But is that rational, Commissioner?

COMMISSIONER STREUR: It is rational, and we do have to take a look at that group. When I read it, I read it entirely differently than it's being interpreted right now, but no; it -- people above my pay grade, way above my pay grade -- lawyers -- have -- excuse me. I didn't mean to point you out, ma'am. People well above my pay grade have determined that that is the correct reading of it, and the folks would be exempted. If we make a decision to expand, I can't see us splitting hairs like that because, if we make a decision to expand, we're going to make a decision to expand because we believe it's better and we can afford it.

COMMISSIONER MORGAN: But if you do make the decision not to expand, I mean, that is possible in the realm of possibilities. I would think that the State Commissioners of Health or your position would say, hey, we've got this little anomaly. If we don't expand, let's, at least, let these guys have the same percentage of slide or credits from 100 up to

400, as you do -- prorated kind of stuff -- from that down to zero. I mean, that way, they're not having to deal with either buying it, which they can't. And as was pointed out yesterday, which is absolutely true, they'll just have to pay the tax, I guess, depending on how that works out.

So anyway, it would seem that -- I think we don't have a crystal ball, but we know there might be a few states that won't expand. So shouldn't we kind of take care of that little problem and not throw that into this process?

COMMISSIONER STREUR: We can do that, but I think that the Governor Beebe waiver is going to raise the awareness of that. If he's granted a waiver based on zero to 400% in the Exchange and run all those folks through the Exchange, I would think that HHS needs to take a look at that anomaly that they have in law. And I'm not promising we will look at everything, but you know, we need to analyze that. We need to identify where the need is, and you know, give people a parachute if we can, and if there is not additional cost to the State, we need to be promoting that.

COMMISSIONER MORGAN: When did that happen, yesterday or something, the Arkansas.....

COMMISSIONER STREUR: No. It was right after the NGA meeting. Governor Beebe and Governor Parnell both had meetings with the Secretary of HHS, and Governor Beebe floated it, and Governor Parnell came back with it. I immediately

jumped on Josh to find out all that he could, and he spent a couple of days finding out that it was a twinkle in Governor Beebe's eyes, but his folks hadn't really fleshed it out yet.

CHAIR HURLBURT: Val, yeah (affirmative)?

COMMISSIONER DAVIDSON: So I guess I had a question about the federally-facilitated exchange. I know that, under the law, the federal government is required to set up, in 31 states, multi-state plans that will be available in 31 states. And unfortunately, we don't have clarity about which of those 31 states those might be, but I wondered if, in your interactions with the Insurance Commissioner and the Governor, et cetera, you had heard, at all, from the Office of Personnel Management who will be administering that multi -- or who will be helping to develop the multi-state plan?

MR. APPLEBEE: That's an excellent question, and I have asked that question on several occasions and have not gotten the clarity -- the clear answer that we're both looking for, but if I do get one, I'll be happy to make sure that you get it.

COMMISSIONER DAVIDSON: And then the other question I had -- I guess first a statement that, you know, we have been very clear that, you know, we did commission our own studies, and we have been -- ANTHC commissioned our own independent analysis. Everybody has been provided a copy, so you know what it says. But as we have said repeatedly, this is a very

big decision that governors are being required to make. Unfortunately, the Supreme Court decided that Medicaid expansion is optional; it's not mandatory. The irony is that the Affordable Care Act solved one donut hole with Medicare Part D in terms of prescription drug payments, but inadvertently created this other donut hole with -- as Dave mentioned today -- we talked about it yesterday -- the availability of people to be able to purchase insurance through an exchange who are up to 100% of the federal poverty level, and we know that that is a really serious decision that the Governor is having to make. It has huge implications for Alaska and so we appreciate that he is taking the time to study that very carefully.

I guess, as we move forward in those conversations and as other states are looking at what kind of flexibility there might be, I think we would be interested in hearing what those options are. So if you hear that a state has been fleshing this particular idea and HHS has said, heck, no, we're not even going to consider that or maybe a -- you mentioned who blinks first, and maybe in the blinking process back and forth, if we can have a sense of what the range of flexibility is, I think it might help us to be able to track the issue in terms of what's beneficial for Alaska.

COMMISSIONER STREUR: Absolutely. We will share that because it's -- there is a lot out there, and people are

getting innovative, and the Feds are finally beginning to be willing to talk about it to ensure that, you know, these 17, 24, whatever it is remaining states, at least, put their toe in the water, and to do that is to start looking at different ideas.

In the last two weeks, we've seen more movement on the part of the federal government to look at alternatives than we've seen in the last six months. That may be an exaggeration a little bit, but more than we've seen in a long time. And we look at every one of them. We jumped on this Arkansas thing, thinking that, you know, this could work because what it effectively does, it puts everybody in the Exchange, and the Feds reimburse the expanded population. Basically, Governor Beebe would be able to bill the Feds the premium that they would have. They have a contract for the Blue Cross type entity. The Feds would allow Governor Beebe to put it on his Medicaid cost reports, get reimbursed the cost of the premium through the Medicaid cost report, and the state risk is reduced, plus it allows him to expand and say, you know, if everything goes south in three, five, six years to say, okay, the Feds have pulled the money. That's how the program was funded. So there is a parachute there for the state. It's not something you want to see, but that's what a lot of the hesitation on the part of the state is, are the Feds going to be there for as long as they say they're going

to be there, and I'll tell you that's not a guarantee. You know that.

CHAIR HURLBURT: Thank you very much, Commissioner and Josh. I think you're chairing this session.

COMMISSIONER ERICKSON: I think so. Lisa and Bev, if you could join us, I'll transition right away into our next presentation, which is an Update on Healthy Alaskans 2020. And actually, would you guys mind coming up here to the head of the table? I get scolded by the Commission for making them play ping-pong and going back and forth, if there are slides on one of the end of the table and the speaker is on the other end of the table, and they get whiplash. And so I'm going to turn this seat over to you, just with a quick reminder.

Dr. Hurlburt has another meeting he needs to get to right away. Dr. Stinson had surgery to perform. And so they're having to step out right now, for the record, and I'll just facilitate for the last session of our meeting today.

COMMISSIONER KELLER: I hope Dr. Hurlburt isn't the patient.

COMMISSIONER ERICKSON: And just with a reminder, Jill Lewis and Beverly Wooley introduced the Healthy Alaskans Initiative to you all at our August meeting this past year, and we're coordinating and tracking very closely with what they're doing because we do have, in our statutory mandate for the Commission, a responsibility for identifying strategies

for improving the health of all Alaskans, in addition to addressing issues related to affordability and access to and quality of healthcare. And the work that these leaders are doing is essential to our work in that area. So anyway, they are here to give us an update on the Initiative.

MS. AQUINO: Hello. Hi, I'm Lisa. I'm really happy to be here. What's that? Oh, my bottle's in the way. Hey, sorry. Everyone on the phone, it's a bottle of water, just in case you were thinking something else.

I had just started working in this position when this first presentation was made by Jill and Beverly, and I heard it, but that's why I didn't make it before, but I'm really happy and excited to be here now to make it. And I guess before we get much into this, I should ask, how many of you were here for that presentation? Oh, great. So a good number of you. So I'm going to -- we're going to really quickly go through the beginning of the presentation because it's really just an overview of Healthy Alaskans 2020.

And so these are the things that we're going to be covering today, as I go through the slides. We'll just overview quickly and then we're going to focus on our Health Status Progress Report, which was released, as well as our two Community of Interest Surveys, which we've done, and then talk about some next steps.

So Healthy Alaskans 2020, it's a statewide initiative to

identify targets aimed at improving the health of all Alaskans and then further to coordinate work, moving forward, to reach those targets.

So we have an overall structure that we're working under, and this is this pyramid. And with their structure, we just really try to involve all the expertise that we have in this state and the voices of as many Alaskans as we could. So that red at the bottom, the Community of Interest, that's really the public. That's Alaskans that have an interest in health and wanted to provide some input on this process. And so we've had a couple of different surveys, public surveys on the Internet where people have been able to give us their opinions, let us know what their priorities are and that's been integrated into this process. And then this builds all the way up, using the expertise that we have in this state in terms of data and Health Subject Matter Experts, all the way up to our Steering Team, which is made up of four folks. It's the CEO of ANTHC, as well as Dr. Jay Butler from ANTHC, and then Commissioner Streur and Dr. Hurlburt from DHSS and State of Alaska Public Health.

And this is our process. So this slide sort of -- it's a picture to get an idea of our process, and you can see the big "We are here." So we're planning our next Advisory Team meeting as we speak. It's going to be April 1st and 2nd, and our Advisory Team is really made up experts from around the

state who are representing organizations and communities and that are making this recommendation of the 25 Leading Health Indicators, these focuses that we're going to have for the rest of the decade that we'll be working towards.

And the Advisory Team takes in input from the two bubble areas on the side, from the Community of Interest as well as from our Data Team and our Subject Matter Experts, and our Data Team has really worked so hard to pull all the existing that we have in the state. We're really at an exciting time in terms of doing this process because there is so much data available. There are so many groups that have done so many plans. So with this effort, we're really just trying to build on those and align those efforts, not start something new. And then as we move forward, we'll soon be finalizing those 25 Leading Health Indicators and then we'll be identifying and disseminating proven strategies.

And these are some of our deliverables, and you'll see that red checkmark that's blinking there because our Statewide Health Assessment has been completed and was released in January and then the rest of them we're working towards, and I think, most notably, our ongoing partnerships to align efforts and monitor status.

COMMISSIONER ERICKSON: Can I interrupt for just a second?

MS. AQUINO: Sure.

COMMISSIONER ERICKSON: I just wanted to point out to the Commission members, in case you haven't read your whole notebook yet, there is a printed copy of the Health Status Assessment behind tab five.

MS. AQUINO: Oh, good. Thank you. That's wonderful. I'm really glad. Good. That's also available online. It's -- I hope that it's a really useful document. What it really is, is we looked at the Leading Health Indicators from Healthy Alaskans 2010, and we had a team of data experts from around the state and then they updated those. So you'll see all of the trend for those 26 Leading Health Indicators, I believe, that there were from Healthy Alaskans 2010, as well as all the data sources and some information about each of those. And then at the front of that, there is, like, a report card, just a one-pager where you can see everything really clearly, and I think that that's a useful tool. I use it and bring it to meetings. And again, that is available online at our website, which is www.ha2020.alaska.gov.

But just to talk about some of what's in there, so there are 26 indicators in there, and they have targets, and we reached two of our targets. The targets that we reached were reducing cigarette smoking among adolescents and reducing the post-neonatal death rate, and it's very exciting that we met those, and you know, a tremendous job by programs throughout the state. I think this really reflects people working all

over the state in terms of tobacco and working on infant health. But as you can see, there are only two, but in four others, there was movement, positive movement. We didn't quite meet our target, but there was positive movement and that's also exciting, and there is great work being done.

And then you'll see that there are a number of them where there is little to no movement towards the target, and I would say that doesn't necessarily reflect that there isn't tremendous and great work being done in those areas. That isn't the case at all. I think, as you'll hear more from my colleague, Beverly, that this really just demonstrates that perhaps Healthy Alaskans 2010 wasn't set up for success from the start. It was an enormous and amazing effort done by a lot of people that had so much knowledge and so much passion about it, but unfortunately, it didn't have the backing of a coalition of folks statewide and then the funding to continue on and work to reaching these goals. So I think, now, I'll turn it over to my colleague and let Beverly tell you a little bit more about that.

MS. WOOLEY: I'll switch seats here. Thank you, Lisa. It's great to be back and able to talk with everyone. Let's see. Here we go.

So really what we've done is we went back and we looked when we got the results from the Healthy Alaskans 2010 and said, okay, what happened and why didn't we meet that because,

if we're going forward with Healthy Alaskans 2020, we don't want to repeat; we want to learn, and we want to be under a continual process of improvement. And what we really found is that, you know, some of the folks were saying, oh, you know, the State, you didn't do that, using State with a big "S." I like to say it was the state using the small "s" because what we know -- in order to achieve these goals, it is going to require partners across the state in all communities at all levels aligning behind these and moving forward. If this is something that the state could do by themselves, we would have fixed it a long time ago, but it's not. It's very difficult.

And one of the exciting things, as Lisa was showing you our structure that I like to be sure and point out, this is unique also and the first time that we have come together as a tribal entity with the State of Alaska to do an assessment and jointly come forward with identified Health Indicators that we're going to work on for the decade. We've been at each other's tables before, if you will, but now, we're really cosponsoring, saying, you know, we live, work, and play together. We even get our healthcare at the same places. It doesn't make sense to not really join together.

So one of the big differences with Healthy Alaskans 2020 is we've started that from the beginning. We have -- once our Indicators have been identified in FY14, you'll see that we're going to put together an implementation plan. Lisa and I will

probably spend a good bit of our time on the road, going to organizations, going to communities, and really helping them to align with what we're doing so that we can see that movement as we're going forward. We'll also be doing more in the media with getting our general population to understand why this is important and the benefits that it can bring to them, as well as working with policymakers at all levels, at the Legislature, assemblies, but even within corporations and organizations. An organization, such as ANTHC, can have a smoke-free campus. That can go a long way in meeting some of these indicators. That's just an example. So those will be some of the things that we're doing.

We'll also have a very robust online monitoring, so that, any time, people can go on from around the state and plug into any of the final indicators and find out where we are right then, looking at the status and monitoring it, and where the data is available, we'll be able to drill those down to the regions, and looking at even the tribal regions, we've been working closely with the State. Huge change from the last time. And that information will be available, shared widely, and that will also allow us to make mid-course changes as we need to.

And I just wanted to take just a couple of minutes. We did talk to you about doing the initial survey, to let you know that that was a huge success. We had over 1,500 Alaskans

that provided input back to us. That closed at the end of October, and you can see here that the top interests -- and we, basically, were trying to get very wide interests from them. We want to make sure that we aren't doing it to Alaskans, but we're doing it with Alaskans. So we need data, but we need to know what the community is thinking and that's what these surveys are really looking at, so alcohol use and abuse, cost of healthcare, very near and dear to this group, diet, exercise, obesity, other substance abuse and violence. So it's not out of line with what many of us thought. We took this information, along with that health status, and that's what the Advisory Team used to come up with their 71 -- what we now are calling our 71 Potential Leading Indicators, which is where we are now.

We used that to build a second survey, and on this second survey, we're really trying to get folks to narrow down, amongst those indicators, which one is really the most important to them. And so what we were looking at is, if alcohol is important, are you more concerned about binge drinking with youth, are you more concerned about prenatal use of alcohol, is it adults we need to be looking at? So again, hearing from the community, we'll be hearing from our Subject Matter Experts again with this to say, okay, this is what we see across the nation that we're getting the most traction with. We're also looking at other existing plans within the

state to see what's going on with that, as we move forward. These results -- as you can see, the survey has just closed -- unfortunately, they're not available yet or else we would share those with you, but those will be coming out in April. They'll be available online at our website here, and we'll be able to take those forward.

The good news is that we did make a stronger effort this time, particularly getting our age groups a better distribution. We didn't get as many young people with the first survey. We, again, made a mid-course correction. We did our own assessment again, and we targeted that group. That group, we got a lot more from, as well as making sure that the representation across the state has been there, and we were, again, successful.

The second survey, we had over 1,800 people that participated in that. So we've been extremely encouraged with the participation.

One of the things that, quite frankly, we were concerned with going into the survey was that perhaps Anchorage and MatSu area would swamp the survey and we wouldn't hear from our regional folks. I mean, these were some of our initial concerns. So we made a concerted effort to make sure to reach out across the state, and what you see here -- the top line gives you, overall, the population distribution for the different areas. The second line is what we found on the

first response and then the dark blue is what we found with the second. And we're really pleased to say that, really, we had only -- the only percent response from Anchorage/MatSu and the Interior were the only two areas that were slightly below what the percentage of population is, and I should probably be careful, but actually being from Anchorage and MatSu area, within that region, that, often times, is the elephant in the room. It didn't hurt my feelings at all that that one was a little less because I think we have so many opportunities to provide input, and we were really delighted with what we saw from across the rest of the state.

So again, this has been, you know, our effort to try to make sure that we're hearing from all Alaskans and that this really is more of a statewide community process.

And just to wrap up, our next steps, at this point, will be to finish analyzing that data from the second round that we've had. We will and have been working diligently on all 71, now, of these indicators. We are putting together information for our Advisory Team that shows the trend for the last ten years, if we have that, or for as much of that ten years as possible, where that's sitting, and the public health importance regarding that, the data sources, how strong they are, so that they'll be able to use that as we go forward with the community input to help narrow down those indicators from 71 to 25.

So that's going to happen on April 1st. We'll be working that process, and we're doing this -- I have to also say we're really trying to make the best of funding. This will only be our second face-to-face meeting with our Advisory Team. We have been using extensive use of technology through everything from, you know, web-based conferencing to polling, and it's been very, very successful. So I think that we've been able to do that successfully also.

And then once we, again, have those Leading Indicators, we'll follow-up, as we said earlier, with that FY14 of really getting out there and getting the alignment, both with individual organizations, communities, but we'll also be talking at the policy level to make sure there is alignment and getting that information out to the public and also to our providers. I think, last time, another group that was left out, often times, was our providers. And the real idea is to increase the health status for all Alaskans, which, in the long-term, should help to do what you're trying to do, which is to keep that healthcare cost down, so increasing quality as well as saving money.

So I know we're standing between you and the end of the day, so we tried to zip through this as fast as we could. Been there, done that. And wanted to make sure, if there were any questions, concerns, that we could try to respond to those. So thank you.

COMMISSIONER ERICKSON: Thank you, Bev and Lisa. Keith?

COMMISSIONER CAMPBELL: Just one. The community groups, I know several of the communities have wellness groups and things like that. Is that who you contacted in this survey data or how did you get into the local communities?

MS. WOOLEY: The survey data went out through a variety of methods, and it was individuals. It was people, some of them, many of them working within corporations. We can tell that by some of the email tags that are on there. It is a confidential, though not necessarily always an anonymous, survey because people do have an opportunity to provide their name, if they want to. And basically, it was through blast emails, Twitter. We were on Facebook, telling people about the survey, as well as we tried to reach out, such as through ANTHC. We made sure all of our Clinical Directors got it. We made sure that the heads of all of the different regions got it and asked them to disburse that down. The State did similar. So -- and the Advisory Team. Oh, yeah (affirmative). Our Advisory Team, which was about 30 individuals from across the state, has been instrumental in getting that out within their communities.

COMMISSIONER ERICKSON: Other questions for Bev and Lisa?

MS. WOOLEY: All right. Well, and I just would also be remiss if I didn't mention how much Deb has really helped in participating and working with us. She serves on our Advisory

Team, and we actually made folks, when they signed up for the Advisory Team, sign an Agreement Letter, stating that they would put in the time, energy, and effort because we've called on them for hours of work and sent them homework that they have to do and respond back. And so anyone that you know that's on the Advisory Team, they really deserve a big thank you because they've really been working above and beyond for the good of all Alaskans. Thank you.

COMMISSIONER ERICKSON: Well, you're helping us, too, so this is good. So thanks very much for your time, for coming to update us, and we will definitely be in touch.

We're going to wrap up our meeting now. We were scheduled on our agenda to end at 12:15. It is 12:10 right now.

In terms of next steps, I summarized, earlier this morning, what we're going to do related to both the plans for next meeting and follow-up from our brainstorming sessions yesterday afternoon and this morning. I'm not going to repeat that again.

But one other point that I'll make, we'll work, over just the next couple of days, to update and make those modifications and clarifications on the Affordable Care Act Update and get that out to you soon. That will probably be the first thing that you see.

Do any of you have any questions or comments before we

wrap up this meeting and start getting ready for the next one? Val?

COMMISSIONER DAVIDSON: I just thought this was a really efficiently run meeting, so thank you.

COMMISSIONER ERICKSON: Thank you for that feedback. And any suggestions for improvement are always welcome, too. Well, thank you all very much for your time, and we will be in touch. Take care.

12:09:02

(Off record)

END OF PROCEEDINGS