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ALASKA HEALTH CARE COMMISSION

THURSDAY, JUNE 20, 2013

8:00 A.M.

FRONTIER BUILDING, ROOM 896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 1 OF 2

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1 system that we have with prices and he blames it on the  
2 American employers and I think, that you know, as we partnered  
3 with Commonwealth North with our session last fall and we'll  
4 be doing again this fall, we've got a meeting -- they had a  
5 year ago in August, that employers, as they are, you know,  
6 almost always, very humanistic as far as their concerns about  
7 their employees, but they're seeing the health care costs,  
8 it's outstripping everything else and keeping them from being  
9 able to give their employees raises, do that kind of thing.  
10 So that was in there.

11 In terms of -- we talk about evidence-based medicine and  
12 I was in a House Finance Subcommittee here just this week and  
13 one of our elected representatives was -- I mentioned PSAs and  
14 he responded, "Well, I had a PSA and I had surgery and I  
15 needed to do that." There was an interesting analysis that  
16 was done last year and published in the "New England Journal"  
17 that basically said with PSAs, we're now -- we've talked about  
18 it before, the American Neurologic Association has come out  
19 and said, "We no longer recommend universal PSAs for all --  
20 for screening. We think there needs to be a discussion  
21 between the physician and the patient and to make an  
22 enlightened decision on the risks and the downsides," and that  
23 is absolutely huge because that kind of recommendation reduces  
24 the revenue going to neurologists, which is their union, but  
25 very enlightened -- but this study was interesting.

1           It basically said that with the PSAs, there was a  
2 randomized controlled study, which was interesting, because  
3 it's really hard to do with this kind of a condition, but  
4 about 1,500, they were randomly assigned either to what was  
5 called radical prostatectomy, mostly surgery, also could have  
6 been radiation. It could have been brachytherapy, the other  
7 therapies or non-intervention and then the non-intervention  
8 group had two groups. One was called active observation,  
9 which meant bringing back and getting repeat tests and  
10 examinations and the other was just watchful waiting and that  
11 was, "If you have a problem, call me."

12           The difference in cost over 15 years on the average  
13 between the active observation and the watchful waiting was  
14 about \$15,000 per person. Those with the active intervention,  
15 the costs were much greater, where they had the radical  
16 prostatectomies or whatnot, but the outcomes over a 15-year  
17 period and then some went out longer, that the outcomes were  
18 that there was no statistically significant reduction in all-  
19 cause mortality rates and prostate cancer caused mortality  
20 rates, in metastatic rates of cancer between those who had the  
21 non-intervention and those who had the intervention, who had -  
22 - the other may have had intervention later, as appropriate,  
23 but what was interesting, those who had the intervention had a  
24 2.7 times as much urinary incontinence and 1.8 times as much  
25 impotence there.

1           So this week, we talked about evidence-based medicine.  
2           At our August meeting, I think you will find it a fascinating  
3           meeting. We will be focused on evidence-based medicine and  
4           then the final article that I mentioned is a book. I guess I  
5           have not read -- this is a summary. So I'm not recommending  
6           the book, but as a country, we're looking for what makes sense  
7           and how we can reduce costs and some of the people in what I  
8           would consider the less scientific disciplines say, "Well,  
9           there are other things that we can do that cost more or cost  
10          much less than the high-priced doctors and hospitals and so  
11          on." It's alternative and complimentary medicine and I think  
12          we probably recognize there are some situations where that may  
13          help, but this is a book that was published.

14                 It starts out talking about a 12-year-old girl that  
15          develops pancreatitis, very sick, came to the hospital taking  
16          80 different supplements of one kind or another. The mother  
17          carried a shopping bag around and then so, this reminds us  
18          that evidence-based medicine is not intervention. It's not  
19          therapeutic nihilism, but it's making sure what we do is based  
20          on science and that should be whether it's the most advanced  
21          technology available or supplements, if they are indicated at  
22          times, but there is a lot of non-science out there.

23                 So that's kind of behind -- we're going to be talking  
24          about that today and over the rest of the year, I think you'll  
25          find that our sessions will be very interesting to you. We

1 always start by having the commissioners introduce themselves  
2 first and then going through the audience. So we'll start  
3 with that. Jeff, we'll start with you.

4 COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. I'm Jeff  
5 Davis, President of Premera Blue Cross Blue Shield of Alaska,  
6 representing insurers and all Alaskans.

7 COMMISSIONER CAMPBELL: Keith Campbell, I reside in  
8 Seward. I'm the consumer representative on the Commission.

9 COMMISSIONER BRANCO: I'm Pat Branco. I'm the current  
10 and soon to be former CEO of Ketchikan Medical Center and I  
11 represent the Alaska State Hospital and Nursing Home  
12 Association.

13 COMMISSIONER ENNIS: Emily Ennis, Fairbanks Resource  
14 Agency in Fairbanks. I'm representing the Alaska Mental  
15 Health Trust.

16 COMMISSIONER HARRELL: I'm Dr. Harrell. I'm the  
17 Commander out of the Joint Base Elmendorf Richardson Hospital,  
18 representing the DOD and the VA.

19 COMMISSIONER URATA: Bob Urata, family physician from  
20 Juneau, Alaska. I'm representing primary care physicians.

21 COMMISSIONER MORGAN: Dave Morgan representing primary  
22 care and community health centers, but I did bring a book and  
23 the book I think would be -- it can come in an E-book or a  
24 standard book. It's called "Entitlement Spending: Our Coming  
25 Fiscal Tsunami," and it's not long. It's about 150 pages and

1 it was a very interesting book projecting the outcome of costs  
2 and processes for the next 20 years.

3 CHAIR HURLBURT: Thank you. I'd like to interrupt now  
4 and introduce Senator John Coghill. Senator Coghill is the  
5 new representative from the State Senate on the Commission.  
6 Senator Olson has been very interested. He's often been busy,  
7 but with -- Senator Olson has been interested. He was in a  
8 hearing we had on Monday there regarding the Health Commission  
9 and was very pleased and very supportive of having Senator  
10 Coghill come in.

11 In my own working with Senator Coghill on the issues that  
12 he's been interested in, such as the (indiscernible - voice  
13 lowered) bill, I have been so impressed at the way he does his  
14 homework and becomes knowledgeable and I think that we are  
15 just absolutely delighted. We know you have an incredibly  
16 busy schedule and lots of demands, Senator Coghill, but thank  
17 you for being willing to serve with us. I think you will  
18 enjoy it and learn a lot and I think that it will help you in  
19 your role as a leader in our state, but welcome.

20 COMMISSIONER COGHILL: Thanks for the (indiscernible -  
21 voice lowered) to be here.

22 CHAIR HURLBURT: Yeah (affirmative).

23 UNIDENTIFIED COMMISSIONER: If you want to say something,  
24 John, you've got to push the button and get the red light.  
25 It's different.

1           COMMISSIONER KELLER: I want to say, "Welcome," to  
2 Senator Coghill. This is an intimidating group in the sense  
3 of the knowledge and the expertise and the -- around the table  
4 and I do really welcome you. Wes -- Representative Wes  
5 Keller, Wasilla.

6           COMMISSIONER STINSON: Larry Stinson, I'm a physician  
7 representing the medical providers.

8           COMMISSIONER HIPPLER: Allen Hippler, Chamber of Commerce  
9 for the state.

10          COMMISSIONER PUCKETT: Jim Puckett, Division Director for  
11 Division of Retirement Benefits and I'm representing the  
12 Office of the Governor.

13          CHAIR HURLBURT: And I'm Ward Hurlburt. I'm the Chief  
14 Medical Officer of the Department of Health and Social  
15 Services and the designated Chair for the Commission. For our  
16 next panelist, we'll introduce when we get to that, but if we  
17 could just maybe start to go around the room and if those in  
18 the audience would welcome you all, it's nice to see this  
19 large turnout and if you could just introduce yourself and say  
20 who you may be representing, and if we could just start with  
21 you, sir?

22          MR. KAHUMOKU (sp): I'm Duke Kahumoku. I'm here with  
23 Guardian Flight.

24          MR. RAPPLEYE: I'm Curtis Rappleye. I'm here with  
25 Guardian Flight, as well.

1 MS. BRUCE: Lisa Bruce representing Geneva Woods  
2 Pharmacy.

3 MS. HUDSON: Laura Hudson with Alaska Physicians &  
4 Surgeons.

5 UNIDENTIFIED FEMALE VOICE: Debbie (indiscernible - too  
6 far from microphone) from (indiscernible - too far from  
7 microphone) Health Services.

8 DR. KIESSLING: Bruce Kiessler, family practice, Primary  
9 Care Associates.

10 DR. KRAUSS: Seth Krauss, cardiologist for Alaska Heart.

11 MR. POWERS: Mike Powers, Fairbanks Memorial Hospital.

12 MS. WOODYARD: Liz Woodyard, Petersburg Medical Center.

13 MS. PERDUE: Karen Perdue, President of the Alaska State  
14 Hospital and Nursing Home Association.

15 MS. HOLT: Annie Holt, CEO of Alaska Regional Hospital.  
16 I'm the Chairman of the Board at the -- this year of the  
17 Alaska State Hospital and Nursing Home Association.

18 MS. JACKSON: Good morning, I'm Pat Jackson. I work for  
19 Alaska Native Tribal Health Consortium. I work for Valerie  
20 Davidson, who would be at your table, except that she is in  
21 Bethel.

22 MR. MCCLURY (sp): Peter McClury (indiscernible - too far  
23 from microphone). I'm with the McDowell Group.

24 MR. STREUR: Bill Streur, Commissioner, Department of  
25 Health and Social Services.

1 MR. LEE: John Lee, CEO of Mat-Su Regional Medical  
2 Center.

3 MR. CARSON: Michael Carson, I'm a (indiscernible - too  
4 far from microphone) student (indiscernible - too far from  
5 microphone).

6 MS. PEMBERTON: Jocelyn Pemberton, I work for the Alaska  
7 Hospitalist Group.

8 MS. SCHIEMANN: Gail Schiemann, I'm with the American  
9 Lung Association and I'm representing the Alaska Asthma  
10 Coalition today.

11 MS. STONEKING: Marge Stoneking with the American Lung  
12 Association and Alaskans for Tobacco-Free Kids.

13 MS. HEFFERN: Sandra Heffern, Effective Health Design and  
14 the current Chair of the Anchorage Chamber of Commerce.

15 MS. LONGACRE: Sam Longacre and I'm attending  
16 (indiscernible - too far from microphone) as an assistant.

17 MS. MCGEE: Keli Hite McGee, CEO of Alaska Heart  
18 Institute, cardiology.

19 MS. JUENEMAN: Gloria Jueneman, Alaska Heart Institute.

20 MR. HUMPHRY: Mike Humphry, The Wilson Agency.

21 MR. EGAN: Jim Egan, Executive Director of Commonwealth  
22 North.

23 MR. CHRISTENSEN: Hi, Craig Christensen, Deputy  
24 Commissioner, Alaska Department of Health and Social Services.

25 MS. CULPEPPER: Hi, Delisa Culpepper, Chief Operating

1 Officer for the Alaska Mental Health Trust Authority.

2 MR. HOGAN: Good morning, I'm Bill Hogan, Dean of the  
3 College of Health at UAA.

4 MS. DODY (sp): Janet Dody of (indiscernible - too far  
5 from microphone).

6 DR. FARR: Dr. Ilona Farr (indiscernible - too far from  
7 microphone). I have to go see patients, but I had a question.  
8 Is this meeting recorded at all, so there's some place that I  
9 can go and listen to it later?

10 CHAIR HURLBURT: We do record the meetings and we do  
11 transcribe them. So it's not immediately available, but it  
12 will be available. Jay, everybody is introducing themselves.  
13 Could you introduce yourself?

14 MR. BUTLER: Boy, talk about getting busted. Jay Butler,  
15 Alaska Native Tribal Health Consortium.

16 CHAIR HURLBURT: Thank you, and for you folks that are  
17 helping to make the meeting work, if you could introduce  
18 yourselves, please?

19 MR. JOHNSON: Daniel Johnson, IMIG AV.

20 MS. HEWES: Hi, I'm Sonya Hewes, Accu-Type Depositions.

21 UNIDENTIFIED FEMALE VOICE: Let me just say that's Barb  
22 (indiscernible - too far from microphone).

23 CHAIR HURLBURT: Okay, Barb is.....

24 UNIDENTIFIED FEMALE VOICE: You're turned off.

25 CHAIR HURLBURT: Barb is busy making the meeting work, so

1 she's -- so Barb is over here. Thank you, Barb for all your  
2 work. Let's go ahead and start our -- our first session is  
3 Health Care Finance 101 and this is really.....

4 COMMISSIONER URATA: Excuse me, did Debbie get  
5 introduced?

6 MS. ERICKSON: I (indiscernible - too far from  
7 microphone).....

8 CHAIR HURLBURT: Sorry, Deb.

9 MS. ERICKSON: Deb Erickson, Executive Director of the  
10 Health Care Commission.

11 CHAIR HURLBURT: Thank you. The first session, Health  
12 Care Finance 101, Pat is -- really Pat Branco has opportunity  
13 for this probably more than anybody. We talked as a group  
14 that we wanted a better understanding of -- and Bob Urata has  
15 suggested that getting a better understanding of how our  
16 charge is generated, what are the basis for it, how is it  
17 done, and so we have two folks here to talk with us, one from  
18 the hospital perspective, but also really, from a perspective  
19 of an integrated system, which we're seeing more and more  
20 around the country, not so much here in Alaska, probably  
21 particularly outside of Fairbanks and Ketchikan, maybe Kodiak  
22 to an increasing extent now, but they'll be that perspective  
23 and then from a multi-position medical group here in  
24 Anchorage.

25 We have two presenters; Ken Tonjes, sitting here to my

1 right, who is the CFO for the PeaceHealth Hospital in  
2 Ketchikan, but also the Network Director for the PeaceHealth  
3 System and is based in Bellingham, Washington, is up here  
4 frequently in Alaska, but also has a perspective of the wider  
5 system in the Northwest there that PeaceHealth provides and  
6 then Brandon Ousley, sitting to my left, is the Practice  
7 Manager for Medical Park Family Care, relatively new to  
8 Alaska, but with that group, all of us on the Commission will  
9 remember this, the group that Noah Laufer practices with and  
10 is the Medical Director for and Noah was such a positive  
11 contributing member of the Commission for the year that he was  
12 there and certainly, I developed a lot of esteem and respect  
13 for Noah and so Brandon will be bringing the perspective from  
14 that practice. So without talking more, I'll turn it over to  
15 you, Ken.

16 MR. TONJES: Great. Thank you, Dr. Hurlburt. It's great  
17 to be here. I am the Chief Financial Office at PeaceHealth  
18 Ketchikan Medical Center. I have 45 minutes to talk through  
19 health care finance and obviously, that's -- we're going to  
20 not be able to get into a lot of detail, but we are going to  
21 be able to hit on some of the area that I think are  
22 challenging for our patients, our providers, payers and  
23 regulatory and advisory agencies. So without further adieu,  
24 I'm going to just get started.

25 I provided some basic -- a glossary of terms and this is

1 just a brief example of what's in your packet and starting off  
2 with gross charges, everybody charges price times quantity.  
3 That's gross charges, but a lot of that, that's not exactly  
4 what providers get paid.

5 What we have is -- what we charge -- we have deductions  
6 from revenue associated with that and that's when we charge,  
7 we don't get paid for things, for uncompensated care, people  
8 that qualify for charity programs and/or bad debt, but also  
9 contractual allowances, things that -- entitlement programs  
10 like Medicare or Medicaid or Tricare or other governmental  
11 programs don't necessarily pay charges. They pay perspective  
12 or calculated payments, which are most times less, sometimes  
13 significantly less than charges, and of course, anything else  
14 that's negotiated with any commercial payer.

15 So you take the gross charges less the deductions from  
16 revenue and you get the net patient service revenue, which is  
17 really the cash collected. That is the real revenue for  
18 providers.

19 Income from operations is basically taking all those  
20 operating revenues and subtracting the operating expenses and  
21 that's basically your operations' bottom line. You do have  
22 other non-operating revenue that's generated, things such as  
23 investment income, gains and losses of disposal of assets.  
24 Things that are not patient related fall into non-operating  
25 revenue and you add those two together and you get net income.

1 Another common indicator is days of cash. It's a way of  
2 monitoring if the spigot of cash turned off, how many days  
3 would a provider be able to survive making payroll, paying for  
4 supplies, et cetera and that's your cash and investments  
5 divided by your average daily cash expenses.

6 Then this last one, I kind of want to make this point  
7 about price, payment and cost, and that's a different  
8 definition depending on who you are. For a patient, it's  
9 probably all the same. The price, the payment and the cost is  
10 the same, but for a provider, all of these are different. The  
11 price, as I've described, is the gross charges. The payment  
12 is what we receive and the net revenue and the cost is the  
13 cost of providing the service.

14 So again, at a high level, there's four types of hospital  
15 types; the general, which is the majority of hospitals,  
16 you've got specialty hospitals, which are things like surgical  
17 centers, et cetera, then you've got both rehab and  
18 psychiatric, which can be set up within subunits of hospitals.

19 Then structures of hospitals, you've got public, which  
20 are two types. You've got federal and non-federal and you can  
21 see, I've included the percentage of the composition in the  
22 United States and also in Alaska. The source is American  
23 Hospital Survey in 2011 for national and ASHHNA as of June  
24 2013.

25 You've got not for profit, which are -- the tax exemption

1 is in exchange for providing charitable service and then  
2 you've also got your for profit, which have shareholders pay  
3 income tax, but still provide charitable services. So you can  
4 see in the U.S., 21% public, 58% not for profit, 21% for  
5 profit, a little different in Alaska, 5% public, 86.5 not for  
6 profit and 8.5 for profit. So in our state, predominantly a  
7 not for profit hospital composition.

8  
9 I know this is a busy slide, but the reason I wanted to  
10 show this is just because there's a lot of entities involved  
11 in health care providers and these can all be ownership -- a  
12 provider could own all of these entities or there could be  
13 some combination thereof.

14 So when we're talking about comparing providers, it's  
15 really difficult to find a pure apples to apples comparison.  
16 Common examples are some hospitals own medical groups.  
17 Others, the medical groups are independent. In Alaska, a lot  
18 of our providers or hospitals own long-term care facilities.  
19 That's not the case in the Lower 48.

20 So it's really -- the purpose of this slide is just to  
21 show that within each one of these boxes, it can either be  
22 part of a provider, it could be independent or there could be  
23 some kind of joint venture arrangement as well.

24 As mentioned, Pat Branco sitting on the Commission, I'm  
25 going to share some numbers for Ketchikan Medical Center.

1 These are not meant to -- I'm not speaking for the entire  
2 Alaska community, but I think there are pretty representative  
3 of what goes on and this is kind of the composition of our  
4 gross revenue, 107 million dollars of which 42% is outpatient,  
5 22% is in the medical group. We employ the majority of our  
6 physicians in our community. We have just a couple  
7 independent providers and then inpatient of 36%.

8 So we've heard about the shift from inpatient to  
9 outpatient and how that's occurring and you can see it has  
10 occurred in Ketchikan and we continue to an increase in  
11 outpatient. You take long-term care out or transitional care  
12 out of the inpatient and that's half of our inpatient  
13 revenues.

14 So really only 18% of our gross revenue is generated in  
15 acute care inpatient. That's different than a lot of the  
16 Lower 48, which are still predominantly inpatient driven  
17 entities.

18 There's that 107 million in the payer mix. The pie chart  
19 to the left here kind of shows -- well, does show Medicare at  
20 31%, Medicaid at 19, commercial at 36 and other, all other,  
21 including self-pay at 14%. What's interesting on this is you  
22 can see that the payments are quite different than the gross  
23 payer mix.

24 If everybody paid the same, you would have the same  
25 percentages on the right-hand pie as what is on the left-hand

1 pie, but you can see for all areas, with the exception of  
2 commercial, the payment percentage is less than the gross  
3 payment percentage, which shows that those payers are paying  
4 less, probably, than the cost of providing the service and  
5 I'll get into the cost shift here in a subsequent slide, but -  
6 - so commercial -- for Ketchikan, anyway, commercial payers  
7 make up 36% of our gross payer mix and yet, account for 56% of  
8 our overall payment.

9 As far as hospital price setting, there's all kinds of  
10 ways to provide a price setting mechanism. Most health care  
11 providers use a hybrid approach. We use this, as well, using  
12 a resource based and a market-based methodology.

13 The resource based is -- as a basis, we use national  
14 Medicare RVU ways. The RVUs being relative value units and  
15 RVUs are a way of measuring resource utilization. So if you  
16 have a particular procedure that takes twice as many resources  
17 to provide, it should have a weight that's twice as high  
18 that's the one that you're comparing to.

19 So in this example, there's an X-ray examination of a  
20 wrist. It's got a relative value unit of .92. To set a  
21 price, what we do is we use a conversion factor and we  
22 multiply that conversion factor by all of those weights and  
23 that's conversion factor covers both cost and our margin  
24 requirement.

25 The margin requirement is based on what our capital needs

1 are, you know, to replace aging equipment and also to look at  
2 either new services or new technology. So you also have mark-  
3 ups for supplies and drugs. You can use time studies for OR  
4 minute charges, plus you use -- then you incorporate the  
5 market-based methodologies, which is looking at your  
6 competition, what your payer relationships are and potentially  
7 having loss leaders.

8 So theoretically, I think people would like to think that  
9 every procedure has a unique conversion factor based on the  
10 cost of providing that particular procedure. The reality  
11 though, is that many, if not all, health care providers would  
12 use an overall conversion factor and maybe split it between  
13 hospital and medical group, long-term care or even some other  
14 service differentiation, but the reality is that I would be  
15 hard pressed to think that anybody uses unique conversion  
16 factors for every procedure.

17 This is a common example that we get called for, so I --  
18 that's why I chose it as an example. We get a call from a  
19 patient and they say, "How much is a colonoscopy at Ketchikan  
20 Medical Center," and because we employ or anesthesiologist, we  
21 bill on behalf of our pathologist and we also employ either  
22 the general surgeon or the internal medicine doc that provides  
23 that service, we could either give that patient the cost of  
24 the actual colonoscopy procedure alone, which is either 1,020  
25 or \$1,190 or I could give them the average total cost, which

1 included all the ancillary charges, pharmacy and et cetera,  
2 recovery and physician fees, which is that second box, 4,717.

3 So many times, a patient will call me and say, "Why would  
4 I come to your hospital or your medical group and have a  
5 colonoscopy done when I can have it done elsewhere for" name  
6 the number, \$1,200, \$1,300? I know when I hear that we're not  
7 comparing apples to apples here.

8 The people need to understand -- they need to have enough  
9 knowledge as to what is the right question to ask and the  
10 right question to ask here is; what is the total cost, what is  
11 the total price of the colonoscopy, which includes everything  
12 associated with it?

13 I mentioned cost shifting in an earlier slide and in  
14 simple terms, it's the practice of raising overall prices to  
15 improve payment from a group of offset payment shortfalls from  
16 other payers. In other words, Medicare and Medicaid,  
17 basically, are fixed payments. There's really no negotiation  
18 as to trying to improve your payment mechanism. The only  
19 opportunity to improve your payment is with commercial and in  
20 this simple example, if you have a 50/50 payer mix between  
21 just Medicare and commercial, let's just make it simple, and  
22 you have a 2% margin requirement and I use the critical access  
23 methodology here, which critical access is cost plus 1%,  
24 obviously, if you have a 2% margin requirement and half of  
25 your revenue is paying you cost plus one, the other half is

1 going to have to give you cost plus three to make the 2%  
2 margin that you require.

3 So in reality, we're asking our commercial payers to pay  
4 three times what Medicare pays in order to generate the margin  
5 requirement. That's a simple example. It's not necessarily  
6 the reality, but just to -- for you to understand the concept  
7 here.

8 Again, I'm asked by commercial payers to grant discounts  
9 in Ketchikan and it's a pretty quick conversation. My answer  
10 quickly is always, "No," and the reason it's no is because if,  
11 in fact, I grant discounts to commercial payers, I'm going to  
12 have to continue this practice of cost shifting, which is  
13 going to increase my prices for others, which is going to  
14 disadvantage the folks that don't have an entitlement program  
15 and/or commercial payer backing them up. It's really the self  
16 paying population that's disadvantaged by that.

17 Service is, again, what providers provide as far as their  
18 breadth of service and this is actually Ketchikan Medical  
19 Center's composition of things that require subsidy on the  
20 left-hand side, the negative margin ones, and on the right-  
21 hand side, the positive margin.

22 So our medical group -- we've had groups, physicians come  
23 to us over the course of the last five to 10 years and  
24 basically say, you know, "We want to continue to provide  
25 patient care, but regulation has become just so difficult for

1 us that we're not going to be able to do that and will you  
2 employ us," and so those do, in many instances, require a  
3 subsidy, the same with our transitional care.

4 Well, you can see the list, home health, intensive care,  
5 emergency department, therapies, these are things that you  
6 have to have to provide adequate care to your community, as  
7 far as health care, but they don't all make money.

8 You can see on the right-hand side some of the things  
9 that do and traditionally, imaging and surgery are the ones  
10 that make money and help subsidize some of these lower margin  
11 or negative margin services. So again, going back to the  
12 colonoscopy example, it's unfair, I think, to single out  
13 certain surgical or imaging procedures and say the cost of  
14 these or the price of these is excessive because that's  
15 assuming that every service that the provider provides is also  
16 generating a margin and that's not the case.

17 So again, it's cost shifting. It's service cost shifting  
18 or service price shifting within the provider network. In  
19 order to provide the breadth of services that our communities  
20 demand -- again, that's part of the reason why things are,  
21 maybe in some folks' minds, out of whack.

22 If, in fact, everything that we provided generated a  
23 sufficient margin, and let's just use the 5% margin, if  
24 everything on this list generated a 5% margin, you would  
25 probably see a downturn in some of the prices that are set for

1 imaging and surgical procedures.

2 It's going to get a little more technical now, just we're  
3 going to go over some payment methodologies and the Medicare  
4 hospital perspective payment system. That's how the larger  
5 hospitals are predominantly prospectively paid. You can see  
6 on the inpatient side diagnostic related groups, DRGs, and  
7 APCs, ambulatory payment classifications, all set  
8 prospectively.

9 So again, the charges really for these areas for  
10 prospectively paid hospitals don't really mean a whole lot.  
11 What Medicare is going to pay them based on what they've  
12 calculated to be the appropriate payment. For critical  
13 access, it's cost and it's calculated from the Medicare cost  
14 report and it's calculated based on the latest file to the  
15 Medicare cost report and it's not unusual for us to file three  
16 or more cost reports during the year, interim cost reports and  
17 then a year or two down the road, we finally -- when we're  
18 finally audited on a cost report, we get the final  
19 reconciliation of what actually occurred.

20 So a community hospital is another designation and you  
21 can see that on the inpatient side, it's reimbursed on cost,  
22 which again, is not changed every time you file a cost report.  
23 It's based on a single base year that is inflated forward and  
24 then on the outpatient side, it's paid on an APC.

25 So I put this up here just to show that even Medicare,

1 all providers are not the same and even within PPS, you can't  
2 really -- you're going to get different payments even within  
3 PPS. So a skilled nursing facility is also prospectively paid  
4 on the RUGS system and physician clinics, you've got  
5 outpatient -- hospital outpatient departments, things called  
6 split billing.

7 If they're provider based, you can bill a facility side  
8 as a hospital and the professional side as a pro-fee. The  
9 purpose of this slide is, again, just to demonstrate that  
10 payments are complicated even for Medicare.

11 A simple example to demonstrate that DRG, diagnostic  
12 related group, 194, a simple pneumonia has got a weight of  
13 close to one, .9996, and this is an actual case. Total  
14 charges were \$16,000. What we got reimbursed in Ketchikan  
15 because we're critical access, which is the CAH, was you can  
16 see that our room charge is based on a per diem that's based  
17 on our most recently filed cost report that generates that  
18 cost per day. So it's the length of stay of three multiplied  
19 by that per diem amount. So that payment here is 5,694.

20 The ratio of cost to charges or the RCC is also based on  
21 the Medicare cost report of 48%. So the amount of charges  
22 that we generated times 48% allows for a payment there on the  
23 right.

24 So of a total charge of 16,082, a critical access  
25 hospital would receive payment of 10,501 and the contractual

1 adjustment, the deduction from revenue on this particular case  
2 would have been \$5,580.32. That's for a critical access  
3 hospital.

4 If the hospital was a sole community hospital, which  
5 Ketchikan was before it attained critical access hospital  
6 status, the payment would have been \$7,475 or a little over  
7 \$3,000 less than the payment for being a critical access  
8 hospital. So the contractual adjustment there, a little over  
9 \$8,600, and if it was a prospectively paid reimbursement,  
10 which Ketchikan was before it became sole community, before it  
11 became critical access, the payment would have been 7,038 or a  
12 contractual adjustment of \$9,043.

13 The point here, depending on your Medicare status --  
14 depends what kind of payment you get. So not all Medicare  
15 payment is alike.

16 On the outpatient side, it's a little less complicated,  
17 but based on CPTs, you can see here's two examples, nuclear  
18 medicine and a cardiac stress. The difference between  
19 prospectively paid and sole community and critical access  
20 isn't a whole lot on the cardiac stress. It's significantly  
21 better, though, on the nuclear medicine procedure and again,  
22 that's the difference between the calculation of an APC  
23 payment and a cost reimbursed payment.

24 Now again, remember that these cost payments are set as -  
25 - with the last filed cost report, but they're finalized,

1 they're really kind of reconciled, if you will, one to two  
2 years down the road when Medicare gets around to auditing the  
3 final cost report and either the provider receives additional  
4 payment or if it's determined that they've been overpaid  
5 because their costs weren't as high as what the (indiscernible  
6 - voice lowered) cost report, they'll be required to pay  
7 Medicare back.

8 On the clinic side, there's three methodologies as well,  
9 whether it be a free standing clinic, a provider-based entity  
10 or you also, as a critical access could also build what's  
11 called Method 2. So again, the purpose of the slide, I'm not  
12 expecting everybody to walk away with understanding all the  
13 detail behind this.

14 The point I want to make here is, again, that payment for  
15 -- even for Medicare is complicated and there's many different  
16 iterations that can occur and really, it's difficult to  
17 compare one provider to another provider because the playing  
18 field is a little bit different.

19 Medicaid, we're all the same here in the state. It's --  
20 although it's based on your Medicare cost reports. So from  
21 the hospital side, the state uses a cost report and then uses  
22 that as their base period and then just inflates it forward  
23 for four years, the same with skilled nursing facilities and  
24 on the physician side, it's all based on a fee schedule.

25 Commercial payers, based on whatever is negotiated. If

1 you have it set to charges, it could be on a case rate. It  
2 could be a fee schedule. It could be a per diem. It could be  
3 a capitated arrangement. It's really whatever creative  
4 agreements that the payers and providers can come up with can  
5 be a -- can become a commercial payment methodology.

6 That last bullet there, capitation, is in some of the  
7 recent literature about population health and management and I  
8 think in Alaska, we'll probably be one of the later states to  
9 adopt such a methodology, but it's a pretty big topic down  
10 south as far as, you know, expecting that this is the movement  
11 toward the future that Medicare and others will move toward  
12 population health, giving people a lump sum of money and  
13 expecting them to use that money to address all health care  
14 for that population and actually, you know, (indiscernible -  
15 voice lowered) just using us as an example, we entered into a  
16 strategic alliance with University of Washington.

17 There's no governance change. There's nothing like that.  
18 It's just basically trying to cover our holes, things that we  
19 don't provide, things like burns and transplants, things that  
20 we are, in fact, on the hook for entire populations that we're  
21 going to have to have some arrangement with other providers or  
22 else we'll be at the mercy of whatever they would like to  
23 charge us for that.

24 Now, Alaska is -- this is a topic that I spend quite a  
25 bit of time thinking about because the thing about our

1 situation, there's a lot of travel involved here and there's a  
2 lot of -- I'm not quite sure how that's all going to work out,  
3 but that's fodder for another discussion, I believe.

4 Quickly, I'm going to get into some costs here and you  
5 can see the pie chart. The point I want to make here is labor  
6 costs, salary, benefits, contract labor, for us, 59, basically  
7 60% of our overall cost and within that labor cost, 2/3 of our  
8 labor costs are clinical and just for us, you know, when we're  
9 talking about market, we start with the medical group  
10 management association for our physicians.

11 That's -- they have annual salary surveys, which we use  
12 pretty much to see what the market is for the Northwest and we  
13 increase that 15% for Alaska, just as a starting point, you  
14 know. We end up probably even paying more than that to entice  
15 folks to come here and it's not so hard to entice folks to  
16 come here, but what we're concerned about is retaining them,  
17 you know. It's not recruitment and retention. It's retention  
18 and recruitment and one of our docs continually reminded us of  
19 that, retention before recruitment.

20 So why are our health care costs so high and  
21 particularly, you know, labor costs being 60% of our health  
22 care bucket, you can see, that you know, this is a  
23 professional staff that provides this service to our  
24 communities, you know, RN's, radiology techs, ultrasound  
25 techs, lab techs, et cetera.

1           You can see the median salaries on the right-hand side  
2 and when you figure that 2/3 of your labor force is clinical  
3 and these are the salaries that are commanded by these folks,  
4 it's, you know, those are the costs of inputs and what is your  
5 price supposed to do? Your price is supposed to cover the  
6 cost of providing the service.

7           For Alaska, we do experience maybe some -- I guess I  
8 could categorize these as unique cost pressures. Contract  
9 labor is something I think all Alaska providers struggle with.  
10 Essential staff, you know, moves on for a variety of reasons  
11 and we don't have the luxury of not providing that service,  
12 being either a (indiscernible - voice lowered) for physicians  
13 or any of those aforementioned positions; registered nurses,  
14 ultrasound techs, et cetera.

15           I look at this quite frequently and we spend a lot of  
16 money in Ketchikan on agency staff. Sometimes -- in some  
17 years, it can be as high as 2.5, three million dollars and at  
18 a 30 or 40% premium, usually -- my latest analysis was about a  
19 40% premium we pay agency staff and that's comparing median  
20 salary plus benefits to the actual payment for agency staff.  
21 A 40% premium on three million dollars is at 1.2 million.

22           If I could snap my fingers and eliminate agency staff,  
23 that would be 1.2 million to my bottom line and it would  
24 actually allow me to not have so much price pressure, you  
25 know, to achieve my bottom line, but you know, it's not a

1 fairy tale. I can't snap my fingers and make contract labor  
2 go away.

3 I think it's a fact of life for us and when we are  
4 fortunate to fill some of these positions, we kind of knock on  
5 wood, because it's just a matter of time before we encounter  
6 that challenge once again.

7 I talked a bit about recruitment/retention. Obviously,  
8 the costs to recruit are high. Limited labor pool -- we find  
9 that certainly in some of our rural areas, you know, are  
10 really challenged by a limited labor pool.

11 I don't have to tell you about the cost of living in  
12 Alaska. It is indeed higher and this next bullet about lower  
13 volumes, this is one certainly financial folks, CFOs, struggle  
14 with. The reality is, we just have lower volumes here in  
15 Alaska and those lower volumes result in inefficiencies.

16 An example for us in Ketchikan is we have enough volume  
17 probably to support 1.2 general surgeons, but we have two and  
18 we have two because even one to two call coverage is pretty  
19 crushing. I wouldn't want to do it, but we can't have just  
20 one general surgeon on call 24/7. I mean, that's not a life  
21 for anybody.

22 So we're forced to accept some of the inefficiencies that  
23 may be some of the more urban, down south kind of providers  
24 can -- don't have to struggle with because they have the  
25 volume there to make that all work.

1           Supply costs, barges floating to all Alaskan communities  
2 and we're also embarking on a pretty significant facility  
3 master plan and working with our architect out of Seattle.  
4 Our construction costs are indeed 25% higher in Alaska than in  
5 the Lower 48. You can see the difference there.

6           These are actually our numbers for bad debt and charity.  
7 Historically, back to our fiscal year '08, projected through  
8 the end of this year and estimating next year's budget and you  
9 can see the yellow line there is a percentage of our gross  
10 charges. So remember that our gross charges are a little over  
11 100 million, so we're budgeting an 8% uncompensated care of  
12 bad debt and charity, which is a little over 8.5 million  
13 dollars.

14           I think this is typical for providers, whether they're  
15 for profit or not for profit. I think we all provide  
16 significant levels of uncompensated care and we -- you can see  
17 it's kind of volatile here. This is a hard one for me to  
18 nail. I don't know how many self-pay folks without resources  
19 are going to present, but I do know that when they do present,  
20 we're going to provide them service and this is going to be  
21 what it is.

22           I was asked to address some of these other information,  
23 particularly a charge master and what it is and what it does  
24 and I think this came out from maybe the bitter pill article,  
25 or you know, somebody was interviewed like asked what the

1 charge master was and they didn't know what the charge master  
2 was and -- well, the charge master has been around and it's  
3 predominantly a finance, patient financial services/billing  
4 document.

5 It didn't surprise me that asking a clinical person, they  
6 wouldn't have a lot of knowledge around what a charge master  
7 is, much like, if you know, I guess an analogy would be if you  
8 asked a finance person what's the best way to stop a bleed. I  
9 don't think that's the appropriate person to ask that  
10 question. Just like I don't think a clinical person is the  
11 appropriate person to ask what a charge master is, but a  
12 charge master is a list of procedures, et cetera, that  
13 providers charge and it can have these common elements, things  
14 like charge master number, what the description is of the  
15 particular item to charge, the amount, the revenue code, which  
16 helps facilitate billing and payment, department numbers,  
17 which helps facilitate accounting, general ledger, et cetera,  
18 either CPT or HCPCS.

19 Again, these are billing and regulatory requirements,  
20 including modifiers and the aforementioned relative value  
21 units. So we have 5,600 charge items on our charge master.  
22 Probably larger facilities have significantly more than that  
23 and this is, indeed, how we generate our gross charges from  
24 services that are provided and through our charge mechanism.

25 Cost report, I've talked about and it's an annual report.

1 There's a final one that's required, I think it's five months  
2 after the end of your fiscal year and everybody that  
3 participates in the Medicare program files a Medicare cost  
4 report.

5 It's a little more important, I think, for critical  
6 access hospitals than it is for prospectively paid hospitals.  
7 It used to be much more significant for prospectively paid  
8 hospitals, but now, you can see in the box below what the cost  
9 report does. Primarily for critical access, is it calculates  
10 the payment, the cost-based payment for prospectively paid or  
11 sole community. It looks at kind of additional payments for  
12 bad debt, disproportionate share, which is whether a provider  
13 is seeing a disproportionate share of Medicaid patients  
14 compared to the norm and also a mechanism to provide  
15 reimbursement for providing medical education.

16 So the -- how's the cost report accomplished? You've got  
17 in purple there, the inputs from the entity's financial  
18 statements, both on the expense side and the revenue side.  
19 The cost report adjusts those by taking out non-allowed  
20 expenses, things like physician expenses are not allowed.  
21 Then there's overhead allocations.

22 There's a step-down methodology. It is pretty  
23 complicated that -- when that's all said and done, you get a  
24 fully loaded cost by department and that allows then Medicare  
25 to calculate cost per diem and then you are able to multiply

1 that by you Medicare program days and that gives you your  
2 Medicare program, routine program costs and then you're also  
3 able to calculate your ratio of cost to charges.

4 That's multiplied by your ancillary Medicare program  
5 charges. That gives you your ancillary Medicare costs, which  
6 gives you -- you add those two together and that gives you  
7 your Medicare program cost.

8 This slide, I wanted to show just to show again, this is  
9 the revenue cycle. I'm not going to go through each one of  
10 these steps, but it shows as a patient presents in the left-  
11 hand side, the dark blue, what happens when they actually --  
12 well, when a patient is considering receiving the services in  
13 the blue. When they present is in the middle, both  
14 registration, counseling, et cetera, and then on the right-  
15 hand side is the bill submission and tracking of that and this  
16 is also an area of frustration, I think for everybody.

17 When I get on a plane and somebody asks me what I do and  
18 I tell them I'm the CFO, the next thing out of their mind --  
19 out of their mouth is about billing. That's just the reality  
20 of it and billing is difficult. It's difficult because of all  
21 the complications that I've talked about and the fact that  
22 everybody is different. Everybody is at a different level of  
23 their co-insurance, where they're at with their deductible,  
24 all of those things, which means that every claim, it's  
25 difficult for a provider to be able to tell that patient, or

1 even for the patient to know exactly where they stand as far  
2 as what is potentially going to be owed.

3 We can give them a pretty good idea. It's pretty hard  
4 for us to nail it and when you take a step back, you know, I  
5 don't know if that's where we really want all of our resources  
6 anyway. I think we want our resources more at the direct  
7 patient care level. We don't really want it at the  
8 administrative level.

9 Some trends that are influencing health care, we're all  
10 familiar with ICD-10. That's a requirement and it's replacing  
11 ICD-9. I think many of us are scrambling to prepare for this.  
12 This is -- there's a lot of big deals in healthcare. This is  
13 a big deal. This is rocking a lot of our worlds, but it's  
14 something that we have to do and some of the other trends  
15 here, the quality reporting, the value-based purchasing, the  
16 hospital acquired conditions, the readmissions, I think we've  
17 all heard about, at least they're kind of the pay for  
18 performance. These are the, I think, the (indiscernible -  
19 voice lowered) providers to provide better care.

20 Meaningful use -- many are qualified -- are attempting to  
21 qualify for meaningful use and there's a lot of monetary  
22 incentive to do so, to get everybody wired into electronic  
23 medical records. HIPAA 5010 is kind of old, but it's  
24 something that if you don't have that in place, you're getting  
25 your claims denied and of course, the Affordable Care Act,

1 which we're all -- must comply and I think it's on everybody's  
2 mind and believe me, I don't know who the expert on the  
3 Affordable Care Act is. I know it's not me.

4 So in summary, I know I touched on a lot of things. I  
5 haven't been able to get into a lot of depth, but we would  
6 have to have a significant amount of time to really get into -  
7 - to delve into some of these in depth, but you know, it's  
8 complicated because each input is unique, and when I'm talking  
9 about an input, I'm talking about a patient.

10 When a patient presents, each patient is unique. They're  
11 different. They're different. Their health status is  
12 different, just everything's different about it. So our care  
13 delivery has to be flexible. It has to be variable.

14 Physician orders drive that provision of care, which even  
15 adds to that variability. So when we're talking about, you  
16 know, best practice and those kinds of things, you know, we  
17 strive for best practice, but we still struggle trying to get  
18 there because we're not making a widget. We're not making an  
19 auto part. We've got unique individuals.

20 Hopefully, you now have a better appreciation about  
21 payment, that it's also variable and it can be different  
22 across the board. Regulation is high. Technology changes  
23 rapidly, requiring intensive capital investment. You know, as  
24 we struggle with some of the recent information about, you  
25 know, margins and why are some providers generating higher

1 margins, I can speak for my organization in Ketchikan is, you  
2 know, I mentioned that we have a significant facility master  
3 plan coming up. It's a 76-million-dollar project. Eighty-  
4 four of you, included the furnishing, fixtures and equipment  
5 associated with that. So somebody has to fund that and if I'm  
6 fortunate enough to generate a pretty healthy margin in one  
7 year, I'm earmarking that money for future investment for the  
8 benefit of our community and I think most providers are doing  
9 something similar to that.

10 The last point I would like to make is, you know, there  
11 are many players in health care. Go back to that slide with  
12 all the boxes. So it's hard to -- when we talk about  
13 controlling costs, we can control portions of costs, but we  
14 have to consider the entire breadth of what makes up health  
15 care delivery and that's from -- everything from equipment  
16 technology providers to pharmaceutical companies to medical  
17 groups to hospitals to long-term care, all of those together  
18 comprise the cost of providing health care services. So that  
19 is my presentation.

20 CHAIR HURLBURT: Ken, thank you very much. I think we  
21 will now freeze the clock so that we can -- we probably have a  
22 lot of questions that you generated, but I think we'll have  
23 some time afterwards for discussion later. That was very  
24 helpful.

25 MR. TONJES: Great.

1 CHAIR HURLBURT: I appreciate you coming.

2 MR. TONJES: Thank you.

3 CHAIR HURLBURT: And doing that. If we could turn it  
4 over to Brandon now from the physician group perspective?

5 MR. OUSLEY: Good morning, everybody. Just to, I think,  
6 add onto what some of the things that Ken was talking about,  
7 as far as in the primary care private practice setting, we  
8 look at things -- I was fortunate enough, I talked to my  
9 counterparts in four other clinics in Anchorage to find out  
10 really how they set prices compared to how we do it at Medical  
11 Park and it was nice to see that everybody is pretty  
12 consistent as far as charges, charge price setting.

13 There's a nationwide company called Ingenics and that's  
14 basically the benchmark that everybody I talked to uses. The  
15 range did vary. Everybody was between -- the low end was like  
16 55%. The high end was 75% of the national average, which I  
17 think really makes sense.

18 When I was in the Lower 48, they used the same group and  
19 we would set prices anywhere from 45 to 60. So when you  
20 figure in and factor in, you know, cost of living expenses,  
21 things like that, I think it's fair and you look at -- at  
22 Medical Park, our overhead is 59%, 59.5, compared to the  
23 national average, which is 64. So surprisingly, we're able to  
24 cover our overhead less than what the national average is,  
25 which was actually surprising to me, coming back up.

1           So really, the charge cost setting in private practice is  
2 relatively simple, at least from what the people I talked to -  
3 - I don't know if Dr. Cates or Dr. Urata, you have any  
4 different feelings about it or Dr. Kiessling way back there,  
5 but you know, we review cost charges every two to four years  
6 and that seemed to be for the people I talked to, it was  
7 similar.

8           We do look at individual charges and we will reduce them  
9 compared to what our reimbursement is. So if there's one  
10 certain code that we're getting reimbursed less, there's no  
11 point in charging higher for it when we just have to write it  
12 off anyway.

13           A few of the things that are -- that we are facing  
14 challenge wise, is ICD-10 is huge. It's estimated that the  
15 cost, just on the EMR side to convert over to ICD-10's is  
16 anywhere between 20,000 and \$25,000 per provider. So you take  
17 a group like mine that has 14 docs and that is a big chunk of  
18 change and you couple that with the estimated lost production  
19 going to ICD-10's is anywhere between 230,000 and \$240,000 per  
20 physician, just for the extra work that it's going to take. I  
21 mean, the codes are expanding tenfold.

22           So that, when you just couple -- when you just factor in  
23 ICD-10's, it's huge and I think a lot of that is where you're  
24 seeing the cost go up. We have that piece factored and we  
25 have the Medicaid expansion.

1           You know, I came from -- I just came up -- back to Alaska  
2 from Utah where they just had a meeting, the state Legislature  
3 and they're estimating that it's going to cost the tax payers  
4 324 million over 10 years just in Utah, which doesn't have a  
5 real large population. I mean, it's larger than ours, but  
6 that -- we have that piece coming in.

7           We have, you know, one of the specialty clinics, I talked  
8 to the folks at Alpine Neurology and she wanted me to bring up  
9 -- you know, we were talking cost shifting, things that we  
10 have to do. We were looking -- they have to, it's a Medicare  
11 rule, we all know that they have to have a translator whenever  
12 it's requested at \$80 an hour, two-hour minimum.

13           She says any time that they have to have a translator  
14 come in, they -- they're just -- everything that -- all the  
15 charges that come through are negative. That right there  
16 takes care of the whole visit for them and we have to make up  
17 for that somewhere. So you take that, you know, say that 1%  
18 decrease, we have to make up for it on 3% on the commercial  
19 side and now goes from probably a 5% or 6% increase on the  
20 commercial side for a visit like that.

21           So you see that's -- really in the private sector, that's  
22 what we're seeing. The -- some of the things that he went  
23 over were very similar to what I saw. I was working for a  
24 nonprofit group in Virginia and also with HMA in the Lower 48,  
25 and they set their costs and charges a lot -- very similar.

1 Conversion factors are huge.

2 What else do I have? You know, we reviewed -- it was  
3 interesting. We just reviewed some DME equipment when I first  
4 got here. I've only been back up -- I've been back at Medical  
5 Park for three days now. So I'm still trying to get a handle  
6 on it, but it's not going too bad.

7 There's -- your -- it takes -- I have 14 physicians that  
8 work under me. We have 84 employees and a lot of those are in  
9 billing. You know, it's putting a strain on our clinical  
10 staff because we do need to have so many people in billing and  
11 medical records now because it is so complicated and we're  
12 also facing a shortage of, you know, our salaries are going up  
13 because of -- not necessarily with us, the physician shortage,  
14 but us, in private practice, are faced with the challenge of  
15 paying nurses -- trying to -- how do we recruit them away from  
16 the hospitals, just simply because the hospitals are capable  
17 of paying them more. So that's one of the challenges we're  
18 facing.

19 We're looking at bringing in a nurse manager to oversee  
20 our clinical staff and I reached out to some folks to see, you  
21 know, how their recruiting efforts have gone and two other  
22 groups have been looking for someone for over a year to fill  
23 that role and it's -- the number one challenge was we can't  
24 pay enough to get them.

25 So there's a lot of -- I think more on the operation side

1 on the private practice side that is making costs go up.  
2 We're doing everything we can, you know, our -- my physician  
3 salaries have decreased as reimbursements decrease. There's -  
4 - you can see, it's directly proportional and there's a lot of  
5 concern that the -- the top two concerns that I ran up against  
6 were the ICD-10's and Medicaid expansion.

7 There are some other ways that I think we're looking at  
8 being able to provide good quality care, reducing costs.  
9 There's a lot of talk in the Lower 48 about different ideas on  
10 how we can do that. Hopefully -- I know that there's some  
11 that are being floated around that we'll hopefully see up  
12 here, but it is -- it's a challenge. It's always something.  
13 It's tough to remind staff when they're stressed on a day-to-  
14 day basis of why we're here, you know, everybody that's  
15 walking through that door is sick and they're not happy to be  
16 here, so we need to do everything we can to make that  
17 experience the best for them.

18 I think that's really about all I really have to add. I  
19 know I had about 15 minutes and I think I took 10. There's --  
20 so there are some challenges, but it's -- I think we're  
21 getting there, which is a good thing. It's pleasant to see up  
22 here -- I was in the business of employing physicians for HMA  
23 and it was quite a challenge to -- it's not only us that sees  
24 costs and charges a challenge. I feel for the hospital folks,  
25 because the physicians have a hard time understanding them

1 when they come out of private practice. So it is -- it's  
2 challenging and I don't -- I think that's about all I have.

3 CHAIR HURLBURT: Thank you, Brandon, very much. That was  
4 helpful. If our panel now could gather at the end of the  
5 table and Ken and Brandon, if you could stay here, if we -- we  
6 do have some time for questions. We can maybe have all six.  
7 We have as our panel to discuss -- it's an interactive  
8 discussion with the panel members and the Commission members  
9 there and our presenters.

10 We have Dr. John Cates on my right, on the west side of  
11 the table, I guess, who's a family medicine physician and on  
12 the Board with APS here. Dr. Krauss, who is representing  
13 Specialty Care. Mike Powers, who's the CEO of Fairbanks  
14 Memorial Hospital and the integrated program there that Banner  
15 Health operates with the physicians and then Liz Woodyard, who  
16 is with Petersburg Medical Center, the CEO, bringing a more  
17 rural perspective.

18 So thank you all very much for coming and we can just go  
19 ahead. You may have some introductory comments, but we want  
20 to have an interactive time also. So Dr. Cates, do you want  
21 to start out? You're at the top of the list here.

22 DR. CATES: Sure, I'm probably going to have to start  
23 with an apology.

24 CHAIR HURLBURT: If you could use the mic, please?

25 DR. CATES: I think I pushed the button. Awesome. Well,

1 and do I need this much volume?

2 UNIDENTIFIED MALE VOICE: Yes.

3 UNIDENTIFIED MALE VOICE: Yes.

4 DR. CATES: Okay, got me. I just wanted to start off  
5 with an apology because I kind of trailed in late. That's  
6 number one. Number two is I didn't even really look at this  
7 paperwork until this morning and so I'm going to come from a  
8 private perspective that is probably not expected, but I think  
9 it will create some interesting conversation.

10 First, you know, I think it was Karl Marx that said you  
11 socialize medicine, you're socializing the country and I guess  
12 this is the way we're going. Is that a consensus here?

13 UNIDENTIFIED MALE VOICE: (Indiscernible - too far from  
14 microphone).

15 CHAIR HURLBURT: I think the consensus here, and we've  
16 looked at a lot of comparisons between the U.S. and other  
17 countries, but the consensus is that we have an unsupportable  
18 situation related to health care, but the answer for the U.S.  
19 is not a Canadian answer or a British answer. We need an  
20 American response and certainly in Alaska, at least, we are  
21 very much looking at the private sector, business type  
22 responses feeling that's what's made our country successful.  
23 So no, I don't think we've been following Karl Marx here.

24 DR. CATES: Okay. Well, the reason I got into medicine  
25 was the heart of it and most of us did. I mean, in my class

1 of physicians, I have never seen such a group of altruistic  
2 people that had really the welfare of people in mind and the  
3 track that we're going is yanking the heart out.

4 I mean, the only time -- I mean, when I'm in a patient's  
5 room, an exam room, and examining a patient, it's there. It's  
6 all over the place. It just oozes out. As soon as I walk out  
7 of the room, which is 50% of my time, at least, it's spent on,  
8 number one, on the electronic record, because I refuse to  
9 examine a patient by looking at an electronic record and not  
10 looking at their face.

11 As a matter of fact, I can't do it. So actually now, I  
12 have my nurses coming in and third parties, really, have kind  
13 of impaired the relationship, the patient/physician  
14 relationship and because, number one, now that doctors are  
15 responsible to the patient, the patient is responsible for the  
16 doctor and neither of them is responsible for the bill, right,  
17 because you've got the third party in the middle that isn't  
18 there.

19 So I've been toying with the idea of going into concierge  
20 medicine and I've already evaluated my -- sent them a  
21 questionnaire to see if they were interested, because ICD-10 -  
22 - I don't even have ICD-9, you know what I mean? It yanks the  
23 heart of medicine out and the greatest joy I've had in  
24 medicine in the last, what, 22 years, is when I'm out of the  
25 country. Isn't that sad? I do medical mission work. I've

1 done it in India, Africa, Central and South America and it is  
2 so full of joy. It's -- I can't even relate to you the great  
3 joy of caring for somebody out of the goodness of your heart  
4 with mutual trust and appreciation. It keeps me alive and  
5 I've got to do it every year, because I've got to come back  
6 here and I need the energy.

7 So I'm looking at alternatives and a lot of physicians  
8 are looking at alternatives, but I think concierge medicine  
9 might be pretty effective. You don't have to deal with  
10 insurance companies, number one, I don't think, and you can  
11 still impart care without spending time on the ICD-9 or ICD-10  
12 and it really shaves the cost of your office expenses down.

13 I mean, so -- let's see, the second thing I wanted to  
14 make a plug in -- so the heart of medicine was the last plug.  
15 The next plug is the health of our culture. I mean, I've --  
16 you know, when they started the school breakfast and lunch  
17 program, federal breakfast and lunch program for the children,  
18 two meals a day, seven days a week, 12 months a year, I  
19 actually lost it a little bit.

20 I mean, I got actually really irritated because every  
21 protein product on that is purchased from a large meat packing  
22 plant and is 75% dry weight fat. You know, I think there's a  
23 consensus in the medical community of what causes heart  
24 disease, stroke and obesity and now that obesity, I guess is a  
25 disease, which the AMA just related to us, we can treat it as

1 such.

2 So until we set a better priority of our children and the  
3 next generation, I really don't have much hope for American  
4 medicine and health. So that's one thing.

5 The second thing about the health of our culture would be  
6 just physical education. I mean, we went -- who here at this  
7 table didn't do PE every day when they went to school? Right?  
8 Okay, well, I just read an article just yesterday about TIA,  
9 transient Ischemic Attack, and stroke. Guess what percent  
10 decrease in stroke with an aggressive exercise program --  
11 guess what it is. Anybody? Sixty-four percent decreased risk  
12 of stroke with an aggressive exercise program, with just  
13 aggressive. Yeah (affirmative), that would be over an hour --  
14 about an hour a day of a cardio risk -- a cardio rate of, like  
15 for Seth and I, 135 to 130 to 155, you know. So a moderate  
16 would be half an hour four days a week.

17 CHAIR HURLBURT: Maybe another couple of minutes and.....

18 DR. CATES: You bet.

19 CHAIR HURLBURT: Good, yeah (affirmative).

20 DR. CATES: Moderate would be half an hour of a less,  
21 like 80% cardiac max four days a week. That decreases it  
22 about 31 to 32%. Now that's just one. That's just TIA and  
23 we've got elective PE in the schools. So if we're going to  
24 control medicine and costs, we've got to do something at the  
25 bottom, you know, and I'm willing to go to bat for those kids.

1           Number three, we need to redesign the public health  
2 education program in K-12 and I'd be happy to sit down with  
3 somebody. I think if we can get some cadavers -- I used to  
4 get -- at the University of Oregon, they would let me -- or  
5 University of Washington, they'd let me go through all of  
6 these bags of organs that were pulled out with cancers and  
7 brain, you know what I mean, aneurisms and MI's and amazing  
8 stuff and I would take it to the middle school where my kids  
9 were and I'd lay them all out and they had to tell me at the  
10 end how these people died and let me tell you, there were lots  
11 of oohs and ahs, but it works.

12           Then I went down there and they wouldn't let me go  
13 through all that stuff. It had to be incinerated, but I know  
14 if we got the Anchorage School District to do it, we could get  
15 backing and I could go down there and get the stuff for every  
16 school, every middle school and I'd be willing to go to bat  
17 for that.

18           So in summation, from a private practice standpoint, the  
19 complexities of dealing with patients' medical problems are  
20 sometimes overwhelming and to deal with their spiritual  
21 problems, which I think is a big impact on American health, is  
22 on a different plane and to deal with ICD-10, it's over the  
23 head. So I'm giving a plug for private contracting with your  
24 physician.

25           CHAIR HURLBURT: Thank you very much. Maybe we could

1 kind of go back and forth with a hospital administrator. Liz,  
2 do you want to go next, please?

3 MS. WOODYARD: Okay, well, good morning, everyone, and  
4 thank you for the invitation to be here today. Well, many of  
5 you know Petersburg, Alaska, which is a paradise on earth and  
6 I would have to just start off by saying I know it costs more  
7 to live in Alaska, but where else would we rather be, you  
8 know, and I think it's worth the extra cost and that also goes  
9 to a little bit of extra health care costs, too, because we  
10 chose to live here and it's where we want to be and there's  
11 probably nowhere better to live.

12 So I'll tell you a little bit about Petersburg and a  
13 little bit about our hospital and our challenges there. We  
14 have 3,000 people. We are on an island and of course it's  
15 heavily Norwegian in nature. We just celebrated Little Norway  
16 and so we have a very hard work ethic, a very strong sense of  
17 community, very conservative as far as spending and very much  
18 independent businessmen.

19 We, of course, commercial fishing is the number one  
20 industry. We have the biggest fleet in the Southeast. So  
21 that in mind kind of gives you an indication about how people  
22 may feel about taxes and health care and paying for services  
23 and that gives us a little pause to consider about our  
24 hospital.

25 So we are actually part of the city or borough now and we

1 do not receive any tax subsidy from our borough, which makes  
2 it really, really hard because of the 25% of critical access  
3 hospitals in the country, 2/3 of them do receive some  
4 subsidies from their, either districts or through property  
5 taxes, and Petersburg does not.

6 So 100% of anything we do needs to come from operating  
7 budgets and just to let you know, our labor cost is about 62%  
8 of our total cost and the reason is, is that we are part of  
9 PRS. It's a good thing, but it's very expensive. It's a very  
10 expensive program right now. So that brings the cost up a  
11 little bit.

12 We also have a lot of contract help, as Ken was  
13 mentioning, and we have a gal that came up from Mobile,  
14 Alabama and she started work this week and she said, "I'm  
15 going to go on a diet," and I said, "How come," and she said,  
16 "Well, a bag of potato chips costs \$8.00," and so I said,  
17 "Well, a good reason to get healthy," but so, I think you just  
18 have to put things into perspective.

19 We do have a lot of pressure from the community to keep  
20 our health care costs down and I think the best thing we can  
21 do is education and kind of explain a little bit about health  
22 care costs and just like we've had many discussions, it's  
23 really important that we educate the public about apples to  
24 apples and the total cost of care, for example.

25 Also, we have no economy of scale compared to large

1 hospitals. We have to have nurses in place whether we have  
2 one patient, which is our average daily census on the acute  
3 care side, by the way, is one and we have a long-term care  
4 unit, which absolutely keeps the hospital afloat.

5 If we did not have long-term care, we would not have a  
6 hospital and that's how important it is to us. We do have a  
7 clinic that's owned by the hospital. We have four physicians  
8 and we probably really need two for the size of the community,  
9 but again, it's recruitment and retention. We want to retain  
10 our physicians and have them have a happy work/life balance  
11 because they love being up there and one of our physicians is  
12 leaving in October, but she's enjoyed her visit very much, but  
13 her husband cannot find work.

14 So that's another challenge in a small community is  
15 allowing for our professionals' husband or wife to also find  
16 work and so that's another challenge that we face. Our payer  
17 mix is much the same as probably any other hospital. Thirty  
18 percent is Medicare. About 28% is Medicaid, commercial -- and  
19 then self-pay is about 10. Bad debt, charity care is about 8%  
20 of that, so very similar to other hospitals.

21 One story I'd like to tell you is a little bit about how  
22 small hospitals are really the safety net for the community  
23 and I think that's important to remember as we talk about  
24 health care costs, is we're not going to be everything to  
25 everyone all the time. We can't fix someone's emergency heart

1 attack. They're going to have to get flown out.

2 We're not going to be able to do an MRI. We don't have  
3 MRI's, but what we do have is the ability to provide a safety  
4 net for the community in case of an emergency in a disaster  
5 and a disaster to us was an incident we had about two weeks  
6 ago, where we had a plane crash and we had seven people that  
7 were in that plane.

8 It was a tour group, a National Geographic tour group  
9 that came up, one pilot, six passengers, one dead, six living,  
10 after crashing into a mountain. That, for us, was a surge,  
11 six people. Our emergency room can handle about two people.  
12 We had an overwhelmingly -- number of patients and families  
13 who came to help. Our staff came in. All three of our  
14 physicians who are in town came in, and of course, our  
15 hospital is not going to be getting paid for all that staff  
16 time and physician extra time, all that -- all the food that  
17 we provided.

18 We, the Captain of the boat, everybody that came up, we  
19 fed them. We housed them. Someone stayed at my home, things  
20 like that, but that's the heart of a hospital in small town  
21 and so I do just want to say from a critical access small town  
22 hospital, keep the hospitals. Help us with the financing so  
23 that we can continue to be the safety net for the people that  
24 live there.

25 CHAIR HURLBURT: Thank you very much, Liz. Dr. Krauss.

1 DR. KRAUSS: Thank you for inviting me. My perspective  
2 on health care in Alaska is -- I first started off my career  
3 in -- working for a VA. I was a staff VA cardiologist at the  
4 University of New Mexico in a faculty position and after about  
5 four years, I really began to burn out working in a big system  
6 and not really enjoying clinical care as much and I really  
7 renewed my, you know, vigor for medicine when I came here in  
8 1996 and joined one other cardiologist and we were a nice,  
9 happy two-person group and since then, we've had multiple  
10 iterations of practice schemes and had a moderate sized group  
11 and now, we're part of a large group.

12 In addition, you know, the forces of practice change have  
13 evolved and we're more and more becoming kind of like a big VA  
14 system. We have electronic records. We've had them for about  
15 10 years and electronic records are really -- have been an  
16 innovative important move for safety, I believe, because you  
17 can get access to the patient's chart, assuming that the  
18 records are in there, from any location.

19 However, at the input side, that has changed how we  
20 interface with patients, as J.C. was alluding to. There's now  
21 a distraction. You have a computer and you have to do the  
22 data input. You are basically reduced to a data entry clerk,  
23 and you know, unless you do it well, yeah (affirmative), good  
24 stuff in, good stuff out.

25 So I think that's, yeah (affirmative), has been a

1 distraction, but yeah (affirmative), a necessary part of  
2 practicing now and it's increased the cost tremendously and  
3 I'm trying to frame my comments to the triple aim here and I  
4 want to go back to, you know, quality and quality's a big part  
5 of cardiology and cardiovascular medicine and when I graduated  
6 from medical school back in the 1900's, the survival, if you  
7 had a newly diagnosed congestive heart failure, which is one  
8 of the most common diagnosis and is -- we're always looked at  
9 as the bad guys, because we take care of people with  
10 congestive heart failure and a lot of costs in the American  
11 health care goes to CHF and the survival for someone in 1985  
12 with a newly diagnosis of heart failure was 50% at two years.

13 Now it's about 50% at 15 years and there have been a  
14 number of -- many things that have been innovative and have  
15 allowed people to not only live longer, but have a much higher  
16 quality of life and all of that is very labor intensive.

17 When we see people with heart failure, they come in all  
18 kinds of flavors of heart failure. You have systolic heart  
19 failure, diastolic heart failure. You have to have people  
20 come in frequently for follow-up, for medication adjustments.  
21 You've got to educate people and we're -- the expectation now  
22 is that at 75, if you have a newly diagnosed heart failure,  
23 you're going to be able to keep a person functioning and  
24 living independently and adjusting their medications well into  
25 their 80's, and you know, that becomes, you know, a challenge.

1           People, as they become more frail, it's, you know,  
2 sometimes hard to juggle the list of medications to follow  
3 their (indiscernible - voice lowered) to get their own blood  
4 pressure and so that's very labor intensive and so while we've  
5 improved heart failure prognoses and shortened hospital stays  
6 for heart failure and reduced in hospital mortality for heart  
7 failure, it requires much more effort from, yeah  
8 (affirmative), the clinic, well-trained clinicians, and when I  
9 say clinicians, I include doctors and nurses and mid-level  
10 providers.

11           The same thing goes -- holds true for acute myocardial  
12 infarction. The -- we've reduced mortality for inpatient MI  
13 patients from -- by over 30% in the last 10 years. So again,  
14 that requires a lot of effort, and yeah (affirmative), team  
15 building with high quality services. As typical for a  
16 hospital day, I got home last night after 9:00 and I got -- no  
17 sooner got home that I got called by the hospital about  
18 potentially taking care of a 94-year-old with a heart attach  
19 and ultimately just decided to manage her palliatively or --  
20 and kindly and not put her through a lot of invasive and  
21 expensive testing.

22           So the things that are germane, I think, to Alaska also  
23 are the remoteness of half the population and half the  
24 population lives within 45 minutes to 50 minutes of here. The  
25 other half doesn't and we have people with complicated

1 illnesses who live far away, and that's you know, again, very  
2 expensive, very expensive for them to come in to see us and  
3 it's difficult and challenging to give them the same level of  
4 care when they live in far places and sometimes the pharmacies  
5 don't have their drugs, and so you know, I could go on and on  
6 about the challenge of managing remote patients.

7 Telemedicine has not helped us in private practice as  
8 much, because a lot of it has to do with just getting the  
9 medications, getting blood pressure regulation, getting  
10 periodic labs, but that's, for whatever reason, it is a  
11 difficult thing for us to do.

12 The, I guess the final thing I would like to say is that,  
13 you know whether you're a specialist or a primary care doctor,  
14 I think all doctors come out trained to be very diligent, very  
15 practical, very innovative and I think as J.C. was alluding  
16 to, very altruistic, and you know, we really want to just see  
17 patients.

18 There's nothing more fun than seeing someone I've been  
19 following for 20 -- well, not 20 years, 17 years I've been  
20 here now and it's not uncommon to expect someone to live a  
21 full life after having had a heart attack 20 years ago.

22 CHAIR HURLBURT: Thank you very much. Mike, if you could  
23 go ahead and then we'll have the balance of time for some  
24 interactive discussion.

25 MR. POWERS: Thank you very much. Mike Powers, Fairbanks

1 Memorial. Dr. Hurlburt, I appreciate it, and Ken, I thought  
2 you hit it right on the head, it's very dry stuff. As you  
3 were going through that and as a hospital CEO, what you're  
4 saying is what we attempt to educate our Board about time  
5 after time after time.

6 What I would suggest, just a couple of philosophic  
7 comments on the front end, is just to keep that up. It's that  
8 incremental knowledge of constantly having this in front of  
9 you that finally it's absorbed and you start to put together  
10 some of the pieces of the puzzle, but I think you hit it right  
11 on the head.

12 The other thing is Liz is a former Chief Nursing Officer  
13 at Fairbanks Memorial, left and became a CEO with Banner  
14 Health and a critical access facility in California and then  
15 came up to Anchorage and so she has, as I make some comments  
16 on IT, et cetera, here, she now has that perspective from a  
17 very small hospital, critical access in Petersburg and yet,  
18 has seen that system as well and it might be interesting to  
19 see what some of those differences are.

20 With that said, as I look at the charge here, how do we  
21 achieve the triple aim, and given the constraints of the  
22 current financial management system, and again, the triple  
23 aim, improve patient experience of care, quality and  
24 satisfaction, improve population health, health outcomes,  
25 reduce per capita cost of health care.

1 I think of about 1999 -- '90, and Keith Campbell's  
2 probably Chair of the Hospital Association at the time.  
3 Harlan Knudson was the President. I remember distinctly one  
4 annual meeting. He said it's all about cost, quality and  
5 access, essentially the triple aim. So that's what I want to  
6 frame my remarks around.

7 I thought maybe one of the best ways would be to take the  
8 core strategies of the health -- of the Alaska Health Care  
9 Commission and just tick through what is happening now. We,  
10 at Fairbanks Memorial, are hitting some of these and we're not  
11 hitting some of them.

12 I'll give you an idea of what I think every hospital's  
13 struggling with. Those that are part of a system piece, CHS,  
14 John Lee is here, Banner, Providence, HCA, Annie Holt, I saw  
15 here, have more resources and are under maybe different  
16 pressures coming from a corporate office than those pressures  
17 in the community. Again, education becomes key on keeping  
18 everybody advancing.

19 Health core strategy one from the Commission, ensure the  
20 best available evidences used from making decisions, and I  
21 know you're going to have a special session on evidence-based  
22 medicine next month, this is where Banner, and just to step  
23 back, Banner Health, 27 hospitals, five-billion-dollar  
24 company, 30,000 employees.

25 We, in Fairbanks, are managed. Virtually all other

1 hospitals are owned by Banner. We are managed -- very  
2 independent. Not unlike what you'd expect out of any Alaskan  
3 facility and that gets us into some lively conversations at  
4 times and I think that's part of what we're struggling with  
5 here.

6 For example, we have 44 people in our IT department. A  
7 similar hospital in Phoenix, Arizona supported by a corporate  
8 office has four. Now, we have 44. We have our own box. We  
9 have a lot of independents. We're, I think, more  
10 accommodating to our physicians, but there's a price you pay  
11 for that, obviously, and I think those are some of the things  
12 that you're thinking through, thus the education, education,  
13 education.

14 Nevertheless, ensure the best available evidence is used.  
15 This is where Banner has jumped out in 19 -- in 2000 when  
16 Lutheran Health Systems of the Dakotas, Samaritan out of  
17 Phoenix came together to be Banner and the vision, the goal  
18 was to be a high quality company, not a health care management  
19 company, a quality company.

20 What happened through this merger is to identify  
21 champions, chief medical officers, chief nursing officers,  
22 efficiency experts, engineers, clinicians from around the  
23 system and to establish different clinical consensus groups  
24 and then to identify areas where, through evidence, costs  
25 could be cut, quality could be increased, et cetera.

1           One example is the delirium diagnosis, organ dysfunction  
2 of the brain resulting in decreased mental abilities and  
3 confused thinking. So what some of the protocols that these  
4 various teams came up with and then tried to cascade through  
5 the entire system to say on delirium, here are three areas we  
6 have seen evidence that really improves care, gets the patient  
7 out of the hospital faster, higher -- or better outcomes.

8           One is mobility, early mobility. One of the stunning  
9 things that those with delirium, and I'll defer to physician  
10 colleagues here, but that I understand is when that patient  
11 can get up and is now mobile. So the effort of this team was  
12 to advance the clinical practice that really pushed mobility  
13 for delirium patients.

14           Identity, the challenge to identifying place and self and  
15 where the patient is here and now, and then over-sedation.  
16 Those three areas, through evidence, has helped us reduce the  
17 stay of those particular delirium patients.

18           So where is evidence used? That's one example. This  
19 consensus group that Banner Health is deploying across the  
20 system, it would be interesting to see how other systems are  
21 doing the same thing. I haven't had a chance to talk with Pat  
22 or others, but I suspect these movements are occurring across  
23 the U.S. with this type of cross-fertilization in different  
24 areas of a company.

25           Within our facility, we have a shared leadership

1 function. Many hospitals do. In other words, those people at  
2 the bedside have the best idea what's going on. What are  
3 their -- what are the project you're doing, promoting,  
4 encouraging to undertake?

5 We've got lots of examples of mentoring projects, fetal  
6 monitoring, ED triage, intermittent saline versus heparin  
7 flushes for neonates, bathing practices relative to infection,  
8 ED workplace violence task groups, all of these groups are  
9 working within the hospital trying to provide the best quality  
10 care, posting their results, getting back to this idea of  
11 evidence. What's the evidence in making these decisions?

12 The second core strategy; increased price and quality  
13 transparency. A big discussion in the last month or so, NPR,  
14 and I think it was a "Bitter Pill" article that talked about  
15 some of this pricing. This is where we have to go. I think  
16 everybody in the state agrees. How you do it accurately, I  
17 don't know.

18 We, in 2009, posted our most common outpatient procedures  
19 on our website. So if you go on Banner and you get under  
20 patient services, you can look up the common outpatient  
21 procedures and see what it's going to cost. That type of  
22 transparency, I think is good.

23 I know other, Providence, in fact, posts their quality  
24 outcomes right on their website. We don't do that. We're  
25 going to get there. I don't know of others who are doing it.

1 That level of reporting in transparency is key. So your call  
2 for transparency -- incrementally is happening. It's got to  
3 happen more and thus, the constant call for action.

4 The third core strategy; pay for value. Here's where we  
5 fall short. Jeff would like to see something established this  
6 way. We've talked about it. We certainly are under the gun  
7 relative to CMS readmission rates. You see Ken's slide up  
8 there, patient experience, elements of core measures. Are we  
9 providing discharge instructions, no smoking information,  
10 appropriate antibiotic use, that's occurring at the CMS,  
11 although it's not occurring locally on pay for value.

12 I suspect in this evolutionary incremental effort that  
13 will be a part of the solution some day. It's not right now  
14 and we certainly haven't done that. It would be an area of  
15 focus.

16 The fourth core strategy; engage employers to improve  
17 health plans. We are devising right now employee wellness  
18 coaching for employers in the community. We have lots of  
19 employer health challenges. The University is a good partner  
20 to good-naturedly press -- relative to weight loss reduction  
21 as different entities (sic). We've done that kind of  
22 challenge in the community and then we're exploring nutrition  
23 counseling.

24 Interesting, there's a hospital in southeast Michigan  
25 that had 20 acres of free land and they converted it to a farm

1 and now, once a week, both for their nutrition department that  
2 serves hospital food and for the community, they have a  
3 farmer's market in their hospital.

4 That would be a struggle, I'll tell you, with our Board.  
5 We wouldn't, obviously, do a farm in Fairbanks, unless it's  
6 potatoes maybe, but that would be a struggle because it's not  
7 core. We'd rather focus on assisted living or some unique  
8 issue there, but what you're seeing are hospitals engaging  
9 with the community.

10 I'll mention one thing here real quickly. The fifth goal  
11 of the Commission's core strategy; enhance quality and  
12 efficiency of care on the front end. Here's a controversial  
13 one. Here's where everything you do, there's going to be  
14 issues. We are very proud of affiliating with TVC, Tanana  
15 Valley Clinic, opening access to Medicare.

16 Medicare access at TVC is up like 23%. We have,  
17 essentially by merging, used a more favorable reimbursement  
18 level in radiology and lab to fund that access to care and  
19 Medicare. The care coordination that now occurs has been a  
20 model for how to move patients out of the hospital quicker and  
21 get them to the outpatient setting.

22 Great stuff going on. Now, have we unnerved some of the  
23 physicians in the community? Absolutely. It's a big goliath.  
24 How far are you going? Are you being fair or are you a  
25 monopoly? You know, we're trying to be the benevolent

1 monopoly, but certainly, we're a target and you have criticism  
2 in the community for that. On the balance, we're doing the  
3 right thing in my view.

4 Another great one is Juneau, I think, is where we have a  
5 real issue with behavioral health, especially adolescent  
6 behavioral health in the Interior and we cannot hang onto  
7 psychiatrists and recruit or the community can't.

8 However, the hospital can offer a package that is  
9 attractive. If we can hire those psychiatrists, we can then  
10 farm them out to community behavioral health and some of the  
11 agencies and that's a model that Juneau has used, I think  
12 fairly successfully. We're trying to replicate that to catch  
13 it on the front end.

14 A couple of other things, but I just wanted to take your  
15 core measures and tell you, hospitals are working on these  
16 plans and it's this incremental constant pressure that will  
17 help us evolve. There's no one single magic bullet.

18 CHAIR HURLBURT: Thank you very much. As we transition,  
19 I have been impressed that with Mike Powers' leadership and  
20 with Banner Health there, they are walking the talk that Mike  
21 just described for us. My -- part of my vision, I think we  
22 all share it here, in recognizing that we have an  
23 unsustainable situation in our economy for the cost of health  
24 care. We have an unsustainable situation in our state, where  
25 the state has to drop somewhere between 15 and 20%, maybe, of

1 what we're spending in our state budget and about 30% of our  
2 state budget goes for health care. So that's their big payer.

3 Employers are feeling the pressure with like the  
4 industrialist that we had here last October, but twice within  
5 the last year, once with a jointly sponsored Fairbanks  
6 Memorial WWAMI program in the hospital there with a community  
7 meeting talking about the cost of health care (indiscernible -  
8 voice lowered) medicine, those kinds of things, the hospital  
9 sponsored that and I was up there and presented.

10 The medical director -- the then medical director at the  
11 time of the medical group was there and a part of that and  
12 then there was another session of kind of the young up-and-  
13 comers of the business world in an all-day session sponsored  
14 by the Chamber there, that the hospital sponsored, bringing  
15 these young up-and-coming business leaders, talking about the  
16 issues they will face as employers of health care costs and  
17 the hospital, the Fairbanks Memorial Hospital there, has been  
18 supporting that discussion and that interchange.

19 I think, realistically, the pressure is going to come  
20 from payers to make change, but hopefully, the change is going  
21 to be led by those in the business then, by hospital, hospital  
22 administrators, docs, nurses and others, and I just -- I want  
23 to commend you, Mike, because I think that your organization  
24 is really helping facilitate that discussion there and that's  
25 the model that we need and I appreciate that.

1 I'll start out with a question and then we'll open it up  
2 and this will be a little bit of a put you on the spot  
3 question, Ken, I think. You had one of your slides, number 10  
4 or 11, as I recall, showed that your Medicare reimbursement is  
5 cost plus 1% and that your profit target, margin target was  
6 2%, which I think is modest, quite modest, but that therefore,  
7 you needed to charge commercial payers the cost plus 3% and  
8 then you -- but that would only be a 2% difference, but we  
9 know from what you showed on one of your other slides where  
10 the allocation between your cost structure and your revenue  
11 structure showed the commercial payers being a much greater  
12 percentage than the others, lower.

13 We know from our Milliman studies verifying those  
14 differences in charges, if you need to go from a cost plus one  
15 to a cost plus two, that should be a very, very modest  
16 difference, a 2% difference. How then, do you get to the  
17 pretty broad difference between what Medicare reimburses you  
18 and Medicaid does and what Jeff or any other health insurance  
19 company has to pay?

20 MR. TONJES: Yeah (affirmative), it's a good question and  
21 that example was just a simple example. It was just to show  
22 the -- what a cost shift actually is, right. You're right, a  
23 2% margin is modest. I need more than a 2% margin, but I was  
24 just using that as an example.

25 It's -- I wasn't trying to make the math work, so I mean,

1 that's my explanation. That was just an example if the number  
2 was 50/50 payer mix, which nobody is just Medicare and  
3 commercial, right, so I was just saying the current critical  
4 access is cost plus 1%. If my margin requirement -- let's say  
5 my margin requirement was 4%, right, then obviously, the cost  
6 shift would be even more significant.

7 In reality, I believe the cost shift is more significant  
8 than that, as well. So it's multi-variable. That's why it's  
9 difficult to put an explanation in place, that you know, maybe  
10 the math would work. It would just be so complex that it  
11 would be hard for people to grasp and then you think to Mike's  
12 point, I mean, if that's the case, you'd have to continually  
13 educate, educate, educate until the light goes on and I agree.

14 I mean, I've had CPAs on my stewardship board that have  
15 taken them years, years to really grasp the concepts of health  
16 care finance and these are folks that -- obviously they're not  
17 in health care finance, but they're, you know, they're  
18 financially -- their financial acumen is strong.

19 So I don't know if I answered your question, but I mean,  
20 the slide was meant just as a simple example to what a cost  
21 shift really was.

22 CHAIR HURLBURT: Thank you. Let's open -- yes, Jim.

23 COMMISSIONER PUCKETT: This is a question to Ken, and by  
24 the way, you're not the first CFO I've heard say that we  
25 didn't try to make the math work, so -- but just for a

1 clarification, in your pie chart showing your payers, do you  
2 count a public self-insured plan like the ones that we have  
3 with Alaska Care in the commercial or in your other section?

4 MR. TONJES: It would be commercial for.....

5 COMMISSIONER PUCKETT: It would be commercial?

6 MR. TONJES: Yeah (affirmative), yeah (affirmative).

7 COMMISSIONER PUCKETT: Thank you.

8 COMMISSIONER HARRELL: So for Dr. Krauss and Dr. Cates, I  
9 have a question that you're probably not going to be able to  
10 answer and it's always tough to be thrown a question when you  
11 have not had time to prepare, is my point. Nevertheless,  
12 we've talked about satisfaction and quality and outcomes and  
13 costs and both of you alluded to the negative impact of  
14 electronic health records that it's had on your patient  
15 experience satisfaction parts.

16 We've had three comments thus far regarding the negative  
17 impact on the implementation of ICD-10 and what that's going  
18 to do in terms of driving costs. Getting back, though, to the  
19 driver of your comments, I would like to pose you a king for  
20 the day question.

21 So we have to get to the cost measure here. We have to.  
22 You just heard Dr. Hurlburt say what the state of Alaska is  
23 facing and of course, we all know we're facing. You're king  
24 for a day. You're trying to maintain your relationship with  
25 your patients. What do you propose from a policy perspective

1 as a provider, as MI? What do you propose to rein this in and  
2 maintain that quality interaction that you absolutely desire  
3 and need for your patient?

4 DR. CATES: Well, what I alluded to is if we're not going  
5 to institute a public health education system that's a whole  
6 lot more effective than what we've got and start with our  
7 kids, I mean, and this is long-term, but it's absolutely  
8 necessary.

9 We have absolutely no options to this because of the  
10 consequences of feeding our kids 75% fat in every protein  
11 product and give them two meals a day is catastrophic, not  
12 only from the heart, but cancer, too. A lot of people don't  
13 know that, the relationship of high animal fat to cancer. So  
14 -- and the relationship -- I am probably going to just opt out  
15 of the whole thing and not even bother with it.

16 COMMISSIONER HARRELL: Yeah (affirmative), I heard you  
17 mention concierge medicine. So that was -- and that's where I  
18 was actually driving in terms of what you suggest we all know  
19 is true, but is a generational change and we're faced with an  
20 immediate crisis that requires an answer. So one answer is  
21 you opt out. As a provider, you simply say, "I am not going  
22 to be part of this system."

23 DR. CATES: And that will be the most economical medicine  
24 in the country. It always has been. Before there were third-  
25 parties, we had patients and we had doctors and then we had

1 the mutual responsibility and the bartering that went back and  
2 forth that makes capitalism work, right. Third-party is not  
3 capitalism and it doesn't work.

4 DR. KRAUSS: Good question, and I'm not an economist, but  
5 I know enough to be dangerous. You know, I think  
6 administrative costs of running a private practice are close  
7 to 35 to 40% and the frustration factor -- we spend -- I talk  
8 to insurance affiliated medical doctors to get procedures and  
9 testing, preauthorize -- we spend -- a lot of other people,  
10 before it even gets to me, a lot of other people have made  
11 phone calls to get things preauthorized and then there's a  
12 tremendous effort and cost to -- in going through denials,  
13 appeals and so that's a big part of the cost of our practice  
14 and, I think, medicine in general.

15 The second king for the day proposal I have is making  
16 sure everybody has access. I was just going through the --  
17 your -- the Commission's -- which page is this here? Sorry.  
18 Priorities, there's a list of things here. Where -- yes, the  
19 -- thank you. The priorities, core strategies, desired  
20 outcomes, and I find it interesting, that you know, access is  
21 sort of in the middle.

22 I'm not sure if this is listed just because you wanted to  
23 get, you know, high quality first, but I think everyone needs  
24 access and there's a lot of small business owners, people who  
25 are employed who don't have insurance and they have a

1 difficult time just getting their basic medications when they  
2 -- when I see them for heart failure or angina or for cardiac  
3 conditions that need ongoing medical treatment.

4 The good news is that most essential cardiovascular  
5 medications are now generic, but it is still a hardship for  
6 some people who just are having a difficult time making ends  
7 meet and I think the third king for a day is what, you know,  
8 J.C. has alluded to is you have patient responsibility.

9 There's no reason why people cannot get out there and do  
10 30 minutes of walking a day and that's part of my mantra every  
11 encounter is you've got to walk. You've got to get out there.  
12 You've got to -- this is a great time of year to get out there  
13 and in the winter, it's tough, but I try to encourage them to  
14 get out there in their snowshoes or skis.

15 Yeah (affirmative), Alaska is hard on people who have  
16 orthopedic limitations for exercise in the wintertime, but you  
17 know, this is a great place if you're, yeah (affirmative),  
18 active to get out there and there's just no reason not to.

19 CHAIR HURLBURT: Thank you. Allen, next. Excuse me,  
20 just -- as far as the folks attending, we do need to keep the  
21 discussion to the folks around the table. I'm sorry. At the  
22 break, I think they'll be some chance for others.

23 UNIDENTIFIED VOICE: Public comment.

24 CHAIR HURLBURT: And we'll have the public comment time  
25 right after lunch. Allen.

1 COMMISSIONER HIPPLER: Is it pronounced Ousley?

2 MR. OUSLEY: Yes.

3 COMMISSIONER HIPPLER: Mr. Ousley, you had mentioned  
4 Medicare expansion and certainly Medicare expansion would cost  
5 the tax payer a great deal of money, but you stated it as if  
6 it were a business expense. How would Medicare expansion  
7 increase your costs of running your business?

8 MR. OUSLEY: Well, and it wasn't -- it was Medicaid  
9 expansion, that it would -- just for the reimbursement, by  
10 expanding the population of the Medicaid folks, it's -- that  
11 is one of our lower reimbursed groups and being able to, you  
12 know, when we look at access, the more -- I think it's a hard  
13 pill to swallow, but the more of the lower reimbursed groups  
14 that we bring into the system, the harder access is going to  
15 be.

16 You know, I've got -- I have two physicians, to follow up  
17 on what Dr. Cates was saying, that are looking at concierge  
18 medicine because they're frustrated with the exact same  
19 things. There's -- I think there's a general feeling that  
20 medicine has been taken out of the hands of the physicians and  
21 it's been put in the hands of third-parties and the government  
22 and that's why they're looking at other things, but as far as  
23 the Medicaid expansion, that is the big concern -- is just the  
24 number of patients that will be entering the system that is  
25 already strained with the limited number of providers that we

1 have.

2 CHAIR HURLBURT: Wes.

3 COMMISSIONER KELLER: Yeah (affirmative), this is just a  
4 question about your conversion factor, Ken, and I think,  
5 Brandon, I think you mentioned it, too. So is this conversion  
6 factor calculated for each provider entity and do you get  
7 together at a convention and compare your conversion factors?

8 I think you said and indicated that your service mix  
9 affects the conversion factor and I want to make a little  
10 comment here because it will display, probably display my  
11 ignorance, but I still, you know, I got stuck on it when you  
12 went over it.

13 You talk about the cost of an X-ray exam of the wrist and  
14 a conversion factor there. In a way, there's really no way --  
15 using this system, there's no way to -- I mean, to me, it's a  
16 phony attempt even to say that this is a cost of an X-ray exam  
17 of a wrist, because you can have an imaging place that can  
18 take an X-ray of a wrist and they aren't going to have the  
19 same service mix or the conversion factor has no effects, so  
20 it all has -- to me, as I listened to you, I thought, "Man,  
21 you know, the hospital has got to either completely re-do this  
22 on a cost economy basis per service or something, you know, or  
23 this whole push toward transparency -- I mean, I can see why  
24 it's super frustrating," but go ahead.

25 MR. TONJES: Well, we all have different cost accounting

1 systems. Some don't have cost accounting systems. Some have  
2 fairly sophisticated cost accounting systems, but cost  
3 accounting by definition is an allocation of expense, okay.  
4 So a cost accounting system is estimates. There's actuals,  
5 but estimates -- so by definition, they're estimates and  
6 remember on my slide, I said theoretically, it would be nice  
7 if we had conversion factors or costs for every procedure, but  
8 in reality, it's more of a global conversion factor, just  
9 because of what you just described.

10 It's really too burdensome for us to try -- to attempt to  
11 try to come up with an accurate conversion factor for every  
12 procedure. So basically, as a default, depending on which --  
13 you can have one overall global one, which I think we use or  
14 you -- we use one for the hospital and we use one for the  
15 medical group, right, and our philosophy going in is that the  
16 price of a procedure needs to cover the cost plus whatever the  
17 required margin is with the exception of those that we  
18 determine to be loss leaders or some of those other market  
19 related competitive pressures that might force us or push us  
20 into a position to adjust those.

21 So you're right, the conversion factor is based on global  
22 costs and some might price based on their cost accounting  
23 systems doing it on an annual update. Ketchikan Medical  
24 Center doesn't. Does that answer that.....

25 COMMISSIONER KELLER: Yeah (affirmative), if I could --

1 yes, thank you very much, and if I could, just a real quick  
2 follow-up, because what I hear you saying and telling us is a  
3 push toward transparency is a totally worthless approach  
4 because, you know, the accounting system in the hospitals is  
5 not set up, you know, to get to the point where if I want a  
6 wrist X-ray as a patient, as a consumer, I can go online and  
7 find out.....

8 MR. TONJES: Yeah (affirmative).

9 COMMISSIONER KELLER: .....where I would go to get the  
10 best price for a wrist X-ray.

11 MR. TONJES: Yeah (affirmative).

12 COMMISSIONER KELLER: Because I have to take things into  
13 account, for example, whether I'm community minded or not. If  
14 I go to the, you know, the hospital in wherever, you know, in  
15 Fairbanks, then I'm paying for things like the emergency  
16 service that is available to the community.

17 MR. TONJES: Yeah (affirmative).

18 COMMISSIONER KELLER: It's a community effort. Whereas,  
19 if I go to the -- say to Arizona, you know, there's no benefit  
20 at all to the community that I'm there. So what I think I  
21 heard you saying in your presentation of the way the  
22 accounting system works is that you're -- basically it's a  
23 negative statement on the transparency push that we're going  
24 on -- if we're looking at the market.

25 MR. TONJES: Well, I am not sure I'd categorize it that

1 way. I think -- I think it is challenging to be transparent  
2 at this point. We have to start somewhere and I don't think,  
3 initially, we're going to -- it's going to be -- out of the  
4 gate, it's going to be perfect, right.

5 So starting somewhere is probably the right approach. So  
6 we have to set out expectations, that you know, price  
7 transparency right out of the gate is probably -- it's going  
8 to take some iterations to get it to where we need it to be.

9 There are challenges on the cost side. There's  
10 challenges on the payment side. That's what makes it  
11 complicated is, you know again, remember the slide that said  
12 if we were on the service mix, if everything was paid with the  
13 appropriate margin on there, then we wouldn't have an issue  
14 like we described as far as transparency.

15 So it's not just the cost input. It's also the revenue.  
16 There's the revenue and costs sides, which together, make it  
17 pretty complex. So I mean, just to answer your question, I do  
18 think we need to be transparent. I think we need to start  
19 some -- we need to start doing that and then over the course  
20 of time, the iterations will -- we'll get better at it.

21 Doctor -- you know, if -- while I've got the microphone,  
22 I just want to throw out -- because one of the questions Dr.  
23 Harrell asked, you know, with the 15% reduction -- my opinion  
24 would be -- what does this Commission need to focus on? It's  
25 number seven. Focus on prevention. Eliminate the demand

1 before you even get involved with the provider. That's the  
2 key to these 15% -- you're not going to find 15% costs.  
3 You're going to find it on utilization. That's where the  
4 focus needs to be. Thanks.

5 CHAIR HURLBURT: Emily, yeah (affirmative).

6 COMMISSIONER ENNIS: Thank you. I have a question for  
7 Liz Woodyard. Liz, you mentioned, interestingly enough, that  
8 you felt that or you -- it is the case that your hospital is  
9 viable and remains open because of the long-term care  
10 component that you offer and I assume this is skilled nursing  
11 care provided long-term.

12 Could you just briefly describe or give an explanation of  
13 why this is, that the hospital is dependent on long-term care  
14 and then secondly, if you could address whether this service  
15 meets the needs of Petersburg and the surrounding community,  
16 especially for your aging population? Thank you.

17 MS. WOODYARD: I'm so glad you asked me because it's an  
18 area I really love, but our long-term care -- we have 15 beds  
19 and the reason it's so important is because our beds are  
20 almost always full.

21 So right now, we have 14. We had a death, but usually,  
22 we have anywhere between 13 and 15 residents and then  
23 sometimes, we have swing beds. So we have patients who come  
24 for a swing bed, which of course, they can stay there for 100  
25 days and then they would convert, if they need to, to long-

1 term care.

2 So why it's so important is because 80% of those beds are  
3 Medicaid payers and we greatly appreciate the Medicaid rate in  
4 Alaska. This might not be true in the Lower 48, but I believe  
5 our residents get excellent care with that reimbursement. We  
6 can have activities. We have physical therapy. We have  
7 occupational therapy. We have wonderful nursing care and it  
8 really does help provide for the areas that we really provide  
9 for the community, but don't get reimbursed like the one  
10 patient on acute care, but we have to have the nurses ready to  
11 handle the emergency room, which we don't staff with a  
12 registered nurse, unless somebody comes in.

13 So as far as need, I absolutely think that we will have  
14 more need. We, in Petersburg right now, we have 440 people  
15 who are 65 years old and older and by 2025, we'll have 950.  
16 So 1/3 of the island will be people who are over 65.

17 So it is my thought that -- and hope that someday we can  
18 expand our beds to meet that need, because I do think it's  
19 going to be an increased need. We also do have home health  
20 and we like to have our patients stay home when they can and  
21 that, of course, really doesn't make any money for the  
22 hospital, but it's a service that we feel strongly about.

23 So I think the aging population in Alaska is going to  
24 continue and especially in Petersburg, it's a wonderful place  
25 to retire and so I do think people are going to be needing

1 more long-term care.

2 CHAIR HURLBURT: Okay. One last question, Dave.

3 COMMISSIONER MORGAN: Well, this has an A and B, but it's  
4 very short. The first question, I'm looking at slide 25,  
5 which is your bad debt and charity and I guess my question is;  
6 when you compute your dollars, is that done on gross or net?

7 MR. TONJES: Gross.

8 COMMISSIONER MORGAN: Gross, and I guess the other  
9 question is; as a nonprofit, which you are, I believe, is  
10 providing charity care -- was that the -- if I pulled up your  
11 990 that -- to get the nonprofit, the purpose of your  
12 corporation is to provide charity care? Was that the main  
13 reason? I mean, would you -- with the IRS, you must have a  
14 reason to get non-tax status. So providing charity care was  
15 on that form when you sent it into the Internal Revenue  
16 Service?

17 MR. TONJES: Correct, correct.

18 COMMISSIONER MORGAN: And I guess the other question, I  
19 guess for the Commissioner or to Deb is; what is generally for  
20 industries, what is the bad debt write-off? I mean, that's  
21 how you would find out whether it's exorbitant or large and  
22 that, but what is the difference overall, the average between  
23 your gross and net for all your charges? Is it 5%, 10%,  
24 between cost and your gross overall?

25 MR. TONJES: It's a 60% payment percentage. So the

1 gross, right.....

2 COMMISSIONER MORGAN: So it's -- the gross is 40% more  
3 than the cost?

4 MR. TONJES: Correct, at a breakeven.

5 COMMISSIONER MORGAN: Give or take?

6 MR. TONJES: Yeah (affirmative), yeah (affirmative).

7 COMMISSIONER MORGAN: In some high volume charges with  
8 high payers, you see, I've done this, by the way.....

9 MR. TONJES: Yeah (affirmative).

10 COMMISSIONER MORGAN: Is a little higher and low volume,  
11 that you don't necessarily key -- with lower payer percentage,  
12 usually you don't go.....

13 MR. TONJES: Yeah (affirmative).

14 COMMISSIONER MORGAN: There's no point in raising the  
15 charges because it's not going to make any difference, so.....

16 MR. TONJES: Yeah (affirmative), it's a great question.

17 I think what you're getting at is the industry's always  
18 presented uncompensated care, bad debt and charity as a  
19 percentage of gross charges. That's -- so I wanted to be  
20 consistent with what the industries are always -- always  
21 presented.

22 Remember the slide that said price, payment, cost for  
23 providers is different. All three of those things is  
24 different. For a patient, those are all one in the same,  
25 right. Price, payment, and cost to a patient is all the same.

1 It's different for a provider. So your point is well taken, I  
2 mean, what is the -- if your question is; what is the actual  
3 cost of the uncompensated care that you're providing on an 8%  
4 of gross charges, you know, just at a high level, you would  
5 say, "Well, 60% payment of 8% is 4.8% and if you have, you  
6 know, a 5% margin, so you know, you're looking at 4.5% of  
7 cost," something like that.

8 COMMISSIONER MORGAN: Pat, you've evidently done a study  
9 or a paper on comparing bad debts for health industry versus  
10 other industry, but I'm assuming that's based on gross. I  
11 believe retail, actually, uses net, but I could be wrong.

12 CHAIR HURLBURT: I think Pat has a quick comment. We  
13 need to break because our next session is a webinar and we  
14 have to be back on time. Pat.

15 COMMISSIONER BRANCO: My single comment on it is that  
16 universally across the United States for nonprofit entities,  
17 the charitable contributions are at about 2%. That was a  
18 factor of Hill-Burton -- accepting Hill-Burton funds in the  
19 '60's. To build your hospital, you had to commit to a  
20 contribution in kind to the communities.

21 CHAIR HURLBURT: Thank you. We will start at 10:30 by  
22 the clock on the wall, which is probably a minute or two fast,  
23 okay.

24 10:16:51

25 (Off record)

1 (On record)

2 10:29:57

3 CHAIR HURLBURT: The Commission members, please come to  
4 the table.

5 MS. ERICKSON: And while we have folks coming back  
6 together, Patrick, I wanted to make sure our audio's working.  
7 Can you -- are you there? Can you hear us? Patrick, we're  
8 not hearing you if you're talking. I will send you an email  
9 message just to make sure. Patrick, are you online right now?

10 CHAIR HURLBURT: While Deb is checking to see if we have  
11 Patrick, I'll do the introduction to save time. Patrick  
12 Miller, we had hoped to have here and he wanted to come, but  
13 he needed to be in Washington. So he will be on via the  
14 webinar.

15 He's one of the founding partners for the all-payer  
16 claims database Council and we've heard a presentation from  
17 the Freedman Group in our last meeting. We know there are 12  
18 states now that have implemented an all-payer claims database  
19 and he will give the perspective that's probably been  
20 strongest in New England. He's at the University of New  
21 Hampshire, but we'll be talking about the experience and his  
22 perspective on that, if we get him.

23 MS. ERICKSON: While we work on our technical problems,  
24 maybe we could suggest that Commission members revisit the  
25 questions that you all had raised at the last meeting and

1 since about the all-payer claims database and I included it in  
2 your notebooks behind Tab 3, the heading Preliminary Draft  
3 2013 Findings & Recommendations, that document. If you have  
4 that handy, then -- and go to page three, there are a list of  
5 the questions that had been raised and answers for all of  
6 those, except for the fifth one, which is the main question  
7 for Patrick this morning is; how have existing all-payer  
8 claims databases demonstrated value, and what are some real  
9 life, concrete examples of how the data has been used to  
10 decrease health care cost, improve health care quality and  
11 improve public health, and maybe just as another reminder,  
12 too, when we first started studying all-payer claims  
13 databases, we were looking at it as health information  
14 infrastructure support for two of our strategies.

15 One being transparency, but the other one being payment  
16 reform and as we studied payment reform, we identified one of  
17 the needs related to payment reform is being -- a need for  
18 both providers and payers to have a common trusted data set to  
19 help with modeling and informing -- development of and  
20 identification of financial risk involved with payment reform,  
21 so just a little bit of background you could be looking at  
22 while we're -- and revisiting while we're working on our  
23 technical issues.

24 CHAIR HURLBURT: Maybe just to summarize a little, again,  
25 I think most of us remember what was said, but the all-payer

1 claims database is where you take, as the name is, all payers  
2 provide the information on what they are actually paying for  
3 care.

4 This frequently requires legislation because the  
5 employers who are self-funded, who take the risk for paying  
6 for care for their employees under the ERISA program and then  
7 contract with a third-party administrator to administer the  
8 benefits, do not need to participate in that, in the absence  
9 of legislation.

10 So the states that have implemented an all-payer claims  
11 database have had to have that legislation. The requirement  
12 could be put on the insurance companies, the health insurance  
13 companies without legislation, but it would be incomplete  
14 since a large portion of the coverage in the state is by  
15 employers.

16 The other item that provides information is the hospital  
17 discharge database and we'll be talking about that a little  
18 later today, getting some perspectives on that. One of the  
19 criticisms, I believe, of the all-payer claims database is  
20 that it does not include information on the self-pay kinds of  
21 things that Ken just talked about and other have.

22 So you miss that portion of the hospital discharge  
23 business, but if you're looking at the information as  
24 information that will provide transparency on what is being  
25 charged to various payers, it's available either to an

1 individual as a consumer or to payers who -- employers, health  
2 plans and so on, then it does have the payment information  
3 there. So there are the two issues. We'll be talking about  
4 both of them today here.

5 While we're waiting, then, among ourselves, is there any  
6 further discussion on the last presentation? One question I  
7 informally asked Ken in the break, and something I learned  
8 that I didn't realize before, is where the bulk of the  
9 business that's done in the state is not with critical access  
10 hospitals, that the reality of the critical access hospitals  
11 turns some of the relative position of payers on its head.

12 For example, I have learned and known that Medicaid is a  
13 significantly better payer, about a 38% better payer in Alaska  
14 generally than Medicare is, which is extraordinary among  
15 states. There's one or two other states where that is the  
16 case, where Medicaid pays better and none of them as much  
17 better as here, but the differential reimbursement rate that  
18 Ken confirmed for me with critical access hospital status  
19 reverses that.

20 Since the Medicaid reimbursement is the same across the  
21 state, but that makes Medicaid for Pat's hospital, for  
22 Ketchikan, a worse payer than Medicare is and that was -- I  
23 should have known that maybe, but I didn't. So I learned it.  
24 Any other discussion among ourselves? Yes.

25 COMMISSIONER URATA: Just a comment, is it true or do you

1 keep tabs on it through your department of how many private  
2 practices are being purchased by hospitals? It seems to me  
3 that -- or I'm under the impression that clinics are being  
4 bought out by hospitals down south so that you get bigger  
5 programs together, much like what is going on at PeaceHealth  
6 in Ketchikan and so that physicians are being paid salaries  
7 and not have to worry about business issues and costs and all  
8 that sort of stuff and then you get an economy of scale, plus  
9 you have a system where the patient is cared for as an  
10 outpatient and then there's a hospital for inpatient and so  
11 there's a little bit more control over groups of patients or  
12 populations of patients and so I guess the (indiscernible -  
13 voice lowered) act calls for that, but I mean, do you see that  
14 happening a lot here in Alaska and what do you think about  
15 that?

16 CHAIR HURLBURT: I think it's growing nationally a lot.  
17 I think one difference is that current medical school  
18 graduates, the majority are graduating saying they'd prefer to  
19 be in an employed situation, rather than being an entrepreneur  
20 in their own practice.

21 There was in the '90's, in the days of discussion of  
22 HillaryCare, a flurry of hospitals buying physician practices  
23 and for the most part, that didn't work out real well and part  
24 of it, I think is human nature. There is a tendency for  
25 physicians to become less productive as an employee than they

1 are as an entrepreneur in their own business.

2 What's happened in Alaska is -- in places like Ketchikan,  
3 where as Ken said and as Pat has said, all physicians, except  
4 one or two now, are hospital employees, as Pat told me the  
5 first time we talked about it, they came knocking on his door  
6 and saying, "We're tired of all the hassles" that Ken talked  
7 about and "We just want to be docs and so we want to be  
8 employed there," and it may have provided a little more  
9 economic security for them. They did that.

10 In Kodiak, talking with Don Rush there where they're not  
11 as far down that path as Ketchikan is, but basically, Don told  
12 me that they have hospital employed physicians because they've  
13 not been able to get like surgeons there or ear docs and the  
14 only way they were able to get them -- I'm not sure what --  
15 and I guess Mike's gone, but what the impetus was in Fairbanks  
16 for them to buy the -- to get the clinic there, but that is  
17 the their business model elsewhere. They do have an  
18 integrated system.

19 So I think that -- and the Providence system, where they  
20 and the Franciscans went together in Washington state back in  
21 the '90's and had the three groups and Snohomish, King and  
22 Pierce counties, the only one that really survived was the one  
23 in Snohomish County.

24 In King County, it was interesting that the physicians  
25 unionized and became extremely militant and it was just -- it

1 was a really -- it was like my son being in a union flying for  
2 United. I wouldn't want to have that kind of management labor  
3 relations. It was really bad and it all blew up, except for  
4 Snohomish County.

5 So I think with the ObamaCare and the Accountable Care  
6 Organization, there is a push toward doing that. I think  
7 probably hospital systems think maybe we can do it better,  
8 maybe we've learned, but there's a movement, because  
9 physicians want to be employed more, a movement toward  
10 integrated systems there and it's happening here, but as Ken  
11 said, I think we're behind the rest of the country. Pat, I  
12 don't know if you want to add anything.

13 COMMISSIONER BRANCO: I do want to add a couple of  
14 anecdotal pieces. In the '90's, when we had a flurry of  
15 activity of buying practices because the forecast was going to  
16 be hospitals will be better reimbursed if you have an  
17 integrated health care system and it didn't turn out to be  
18 fact, so people, unfortunately, dumped their primary care  
19 clinics back on the market, said, "Good luck, docs, try to  
20 find your own way through life again."

21 The difference that's happening today is in -- perhaps in  
22 some places, practices are being purchased, but no longer --  
23 the same rules don't apply. We employed a technique called --  
24 it's sort of pay a little more for the practice than it was  
25 actually worth in the '90's, a good will gesture, that there's

1 some intrinsic value associated with the medical records.

2 So we would pay a premium for medical records and I  
3 believe those transferred over. Now, "buying a practice,"  
4 simply means employing the physicians and if they have any  
5 equitable material equipment or furnishings, we bring in a  
6 third-party evaluator to do that, but there's no more --  
7 there's virtually no more buying of practices.

8 The real benefit has come in exactly what you were  
9 describing, some opportunity to divorce yourself from --  
10 almost entirely from the business element of running a private  
11 practice to being comfortable in practicing medicine, but  
12 you're not entirely insulated from the economics of the  
13 environment we're in and that's the difference as we're  
14 beginning to employ.

15 CHAIR HURLBURT: I think that Ken showed it as being kind  
16 of a loss leader. He put the physicians in the column and in  
17 Ketchikan, it's probably easier to make the case for that, but  
18 some of what you read about it is that maybe on an individual  
19 basis, it's a loss leader, but because of where you have  
20 competitive hospital situations where it brings you the  
21 steerage when you own the practice and you get all their  
22 referred patients to the other specialties, a family medicine  
23 doc can be worth a whole lot of money to a hospital.

24 So that probably doesn't get accounted for in the  
25 accounting. I don't know, Pat, you may have some light on

1 that.

2 COMMISSIONER BRANCO: I need to add really quickly,  
3 because Ken gets a lot of criticism for this and justifiably  
4 so, so we love everything about him, but this is one area no  
5 physician -- none of the medical group physicians that have  
6 joined our organization like it when he says -- he shows  
7 negative margin charts because what happens is the  
8 contribution margin is unaccounted for in that way, the lab  
9 tests, their admissions, the X-rays that they order, the  
10 surgeries they perform are not included in the primary care  
11 model.

12 CHAIR HURLBURT: In Ketchikan, you get that anyway.

13 COMMISSIONER BRANCO: That's why we don't include it.  
14 It's just an accounting piece, but -- so when you put it up in  
15 front of physicians and say, "Well, we're happy that we only  
16 subsidize your practice by \$50,000 a year. Hooray, you're  
17 doing great." It doesn't feel very good.

18 COMMISSIONER KELLER: Pat, maybe you would like to  
19 respond to this, but to me, when the hospital management, when  
20 they're thinking about whether or not to put doctors on a  
21 salaried basis -- are probably not thinking, you know at least  
22 directly, I mean, there's a lot of links between the price of  
23 a wrist X-ray and whether or not you have 10 physicians or two  
24 physicians and also, Mike's comment about 44 IT people  
25 compared to four IT people, okay, it has ramifications in our

1 discussion about transparency in the market, because you know,  
2 you're in a sense having to redefine what the hospitals are  
3 and that's restricted by what the Legislatures of the past  
4 have done to you, you know, saying you will do this and you  
5 won't do this, you know, and all of the things that are  
6 imposed on you, but we have to take all of this into account  
7 somehow in the transparency, but my real question is; when  
8 you're making a decision at the hospital level, do you think  
9 in terms -- how do you think in terms -- do you call Ken to  
10 say, "How's this going to affect our price of every service,  
11 you know, that we're going to have to put out there on line?"

12 COMMISSIONER BRANCO: Absolutely, and that was the  
13 question as each medical group or independent physician  
14 knocked on the door and said, "Could we be employed?" Our  
15 first answer -- Ken and I often sit in the same room and have  
16 these instantaneous discussions. The first answer almost  
17 uniformly was, "No." We'd rather invest in trying to keep you  
18 whole and independent. It's probably less of a cost impact to  
19 the provision of care in the community, but I think there is  
20 an element of the Affordable Care Act that will come into play  
21 here soon and that's the fact that the primary care physicians  
22 across the country are going to receive some elevated status  
23 as gatekeeper roles, a much more careful driver in population  
24 health management.

25 The great hope is that it will mirror some improvement in

1 reimbursement, a recognition of that role of that gatekeeper  
2 or that manger role.

3 COMMISSIONER MORGAN: I could pass that. I mean,  
4 basically, so thinking of this in systems, healthcare systems,  
5 you could almost -- this probably sounds a little crass, so I  
6 won't use the word widget, like we have in the past, you're  
7 basically locking down or attempting to lock down bed days and  
8 units.

9 If a physician practice or specialty practices, you  
10 probably could pull the numbers of they do 50,000 lab tests or  
11 20,000 X-rays and what they were, either the diagnoses or the  
12 ICD-9 or 10, because there's crosswalks. I've got one where  
13 you can crosswalk the nine over into the 10's, and so you  
14 basically then make an economic or a business decision; is  
15 this the subsidy or the cost to get the practice or the  
16 employee, the physician, but this is what you're locking down  
17 and adding to your volumes.

18 You may have those volumes now, but they could --  
19 somebody could start a lab or the physicians could work on --  
20 go to Quest and do something or whatever. I mean, I'm -- it's  
21 been 15 years, 12 years since I've worked in hospitals, but  
22 just standing outside and looking in, that's what comes to my  
23 mind on this.

24 It's a wonderful myth and Liz -- I'm going to look at Liz  
25 in the background there. These physicians practicing in our

1 community, it doesn't make any difference whether they're  
2 employed or not on the volume of patients that they refer to  
3 the hospital. It doesn't change anything, even if you do it -  
4 - if you're a really incredible brilliant analyst and can  
5 forecast that they may start an ambulatory surgery some date  
6 in the future and you could prevent it by having them employed  
7 now, they can still do that. They can still break away at any  
8 point and do that.

9 So I'm not that smart. I couldn't forecast well enough  
10 that I could lock them into a contract that would assure that  
11 I have -- that we do all of their inpatient services. They  
12 tend -- hospitals are simply support vehicles for the practice  
13 of medicine. They're the collection point of sick people,  
14 where physicians practice medicine.

15 We can -- administrators can get in the way, can have a  
16 lot of regulation, but essentially, our role is to support the  
17 practice of medicine in a setting, whether it's outpatient or  
18 inpatient.

19 So I wish I was smart enough to be able to forecast that.  
20 That's certainly in play in other places in tight competitive  
21 markets if you could try to find a way that doesn't violate  
22 Stark laws by self-referral or paying people to refer to your  
23 hospital, like people who are a part of the healthcare system,  
24 we can't even do that with PeaceHealth.

25 I can't tell my employed physicians, "Our nearest

1 hospital is in Bellingham, Washington, therefore, you must  
2 refer your patients to Bellingham, Washington." They are  
3 completely free to refer to the proper place for all medical  
4 care without any interference. So I wish it were such that I  
5 could guarantee some financial future, but I can't.

6 COMMISSIONER MORGAN: But relationships are  
7 relationships, yeah (affirmative).

8 CHAIR HURLBURT: Yeah (affirmative), you can still -- you  
9 can have the cardiac surgeons from St. Josephs come up and  
10 say, "We're the best place in Washington. You ought to use  
11 us. It's a little less convenient than Prov (indiscernible -  
12 voice lowered), but you ought to come here." So you can play  
13 off that a little bit, yeah (affirmative).

14 UNIDENTIFIED VOICE: (Indiscernible - too far from  
15 microphone).

16 COMMISSIONER BRANCO: Yes, (indiscernible - too far from  
17 microphone).

18 CHAIR HURLBURT: Right, yeah (affirmative). John.

19 COMMISSIONER COGHILL: Thanks, Doctor. With regard to  
20 Fairbanks and Tanana, from an outsider, I'm not going to  
21 answer for Mike, because Mike had a whole different approach  
22 to it, but part of the debate that I remember hearing was  
23 Tanana Clinic tried for like seven years to get a Certificate  
24 of Need to expand and as the doctors could not make any  
25 forward motion to expand the scope of their facility to get

1 some of the profit making centers, whether it was imaging or  
2 whatever it was, the doctors who were the cooperative members  
3 began to start peeling off, retiring and so -- and it's a  
4 necessary part of that community, so the purchase became a  
5 mutual agreement under some duress, you know, just for the  
6 lack of -- and it's a small community, so -- it's a small  
7 market and Mike alluded to it, it was not without its  
8 controversy, and rightfully so.

9 I remember much of the controversy myself and I benefit  
10 from the hospital. So I'm not trying to poke them in the eye  
11 at all, but they actually had a much larger economic capacity  
12 and there's the good and the bad of that. The good is they  
13 can attract doctors for specialties, you know, when you have a  
14 need for say a pediatric doctor, where the standalone, he just  
15 -- they couldn't -- he or she couldn't do it.

16 Hats off to them, but to control the market in such a way  
17 that arbitrary million-dollar lid just sits on people, the  
18 hospital, because of their community foundation, can actually  
19 move some things that an individual doc can't and many of the  
20 individual docs, I think got buried in that, which creates  
21 some really hard feelings and then you add that to hospital  
22 privileges, the tension just rises.

23 It's just -- it's unfortunate, but in a small community,  
24 that kind of tension was pretty significant as that purchase  
25 came to be. So I know it wasn't without its tension, and you

1 know, I'm a benefactor on both accounts, so -- and as a  
2 policymaker, I tried to take a run at this Certificate of Need  
3 issue.

4 In my view, I thought you need to have a little more  
5 tension in the competitive market, just couldn't get there.  
6 So in Fairbanks, much like your community, is one of the  
7 outliers where that tension really rises to a pretty  
8 significant level.

9 Anchorage has its own issues there, no doubt about it,  
10 but you get a place like, whether it's Ketchikan or Fairbanks,  
11 Kenai, you know, it really plays out in some pretty  
12 interesting ways where the hospital can control, really, the  
13 career of a doctor and that really creates some tension.

14 CHAIR HURLBURT: Thank you all. I think we have Patrick  
15 on the phone. Can you hear me now, Patrick?

16 MR. MILLER: I can hear you, yes. That's much better.

17 CHAIR HURLBURT: We have Patrick on Deb's magic i-Phone.  
18 So Patrick, I've already introduced you. I'm sorry for the  
19 delay, but we do have an hour, but I did introduce you. So I  
20 think we can jump right into it and thank you for being on.

21 MR. MILLER: Sure, thank you for the opportunity. So I  
22 appreciate the opportunity to talk with the Commission today  
23 and provide a little bit more information, hopefully, in terms  
24 of all-payer claims databases and focus specifically today on  
25 areas of usage and what states have been doing with these

1 databases. I understand that's one of the key questions of  
2 the Commission and so we'll go ahead and focus on that.

3 There are some intro slides in your packets, which just  
4 give a little bit of background information on the all-payer  
5 claims database Council. We're a learning network that  
6 focuses on early stage technical assistance for states and we  
7 provide a number of different services to states that are  
8 looking to develop APCDs.

9 There are currently 16 states with legislation, as shown  
10 on the map, they are in various stages of implementation at  
11 this point in time and I'm going to focus on, today, what some  
12 of those states have done in terms of analytics. Not  
13 everybody that has legislation passed is currently  
14 implemented, so we'll be showing a group, a subset of this  
15 group of states.

16 Was there a question? No, okay. In terms of the data  
17 sets, in terms of the familiarity, I think most of the folks  
18 are aware of this, but the states have typically started with  
19 the commercial data and the Medicaid data. We have a number  
20 that have added A, B and (indiscernible - interference with  
21 speaker-phone) data in and several are in the process of  
22 adding the Medicare data sets.

23 The (indiscernible - interference with speaker-phone)  
24 future here, which certainly with Alaska's population for the  
25 tribal population, as well as military, would include VA and

1 IHS. There are currently no states that have been able to  
2 access the claims data from those data sets, but the hope  
3 would be as Virginia and others come onboard that have  
4 military populations, Oregon or Alaska in the future, perhaps,  
5 with Indian Health Service populations, that would allow us to  
6 work with the federal government in a more proactive fashion.

7 We were able last year, just for context, we had about 10  
8 states that did a mini march on Washington to -- actually  
9 Baltimore in terms of (indiscernible - interference with  
10 speaker-phone) to get access to the Medicare data in a more  
11 timely fashion and it actually worked quite well, the states  
12 partnering together with a shared common goal. So I would  
13 imagine we could try to do something similar in the future  
14 with VA and Indian Health Services data.

15 On the next slide, it's really just a comment that leads  
16 into the one after it regarding -- there's been sort of a big  
17 evolution of data sets for states, both in terms of  
18 administrative and clinical data sets, moving from hospital  
19 discharge, Medicaid and Medicare standalone data bases to the  
20 all-payer claims data sets on the administrative side and then  
21 on the clinical side, we have public health registries,  
22 electronic health records, lab systems and now, health  
23 information exchanges in many of our states and there's sort  
24 of this implied need that over time, that data will be linked  
25 together -- is something that several states are working on.

1           In terms of how that's practically happening, on the next  
2 slide, many of the states that build all-payer claims  
3 databases, some of them have been around for more than a  
4 decade prior to the HIE's and now the Health Insurance  
5 Exchanges, the HIX that's starting, in some of the newer  
6 states, Delaware is an example of that, instead of building a  
7 separate APCD, they're integrating the claims data with their  
8 health information exchange and it's just a different  
9 strategy.

10           You still end up with the same result of having the data  
11 that's been collected, but in terms of sustainability and  
12 moving toward a place of data integration from day one,  
13 they're a little bit further ahead or will be a little bit  
14 further ahead, perhaps, than some of the older states that  
15 have things sitting in different data silos, if you will.

16           My final slide before we just jump into some of the usage  
17 examples is really concerned with this issue of data release  
18 and it's sort of where the rubber meets the road, but it's  
19 very important to be having these conversations as you're  
20 thinking about development of an APCD, because it really comes  
21 down to, at the end of the day, once you've collected the  
22 data, who is going to have access to it, under what  
23 circumstances, and what states have done today, is they set up  
24 a myriad of different processes, all pretty similar, to access  
25 the data or there are data use agreements.

1           There's a data application process, data release boards,  
2 privacy boards. It's very similar to an internal review --  
3 institutional review board process that you would find at a  
4 university or at a clinical setting and I think one of the big  
5 questions that states are grappling with at sort of the  
6 earlier stages are, you know, is this data a public utility  
7 that we're gathering, and you know, therefore, what happens in  
8 terms of once it's been gathered?

9           As an example, the state of Minnesota was by statute --  
10 when they set their APCD up, it was very minimal in terms of  
11 who could access it. It could only be used by their health  
12 department and it could only be used for provider profiling  
13 purposes, fairly -- fairly narrow in scope.

14           Other states have set it up much more broadly so that  
15 there are different forms of data release that are shown on  
16 the next slide where there are what we call public use files,  
17 limited use files, so basically copies of the database in  
18 various formats, as well as public websites, public reports,  
19 et cetera that are made available and so this just sort of  
20 gives you a flavor of where some of the states are in terms of  
21 these different types of data release.

22           Much of it, also, depends upon budget in the sense that  
23 if you have a broader data release set of policies, so that a  
24 researcher could go get a grant from a funder to do a project  
25 and then apply for the data. They are then basically creating

1 something that could end up in the public domain, but it  
2 hasn't been paid for by state resources, as an example,  
3 because they've sought additional funding and just another  
4 example, we often see employer coalitions.

5 We see provider organizations and then others requesting  
6 data. So it's not all sort of on the burden, if you will, of  
7 the state to be required to do all the reporting and generate  
8 websites and other things if these data use files are  
9 available.

10 The main difference just between a public use file and a  
11 limited use file, the public use files typically have less  
12 information in them. So they don't typically identify the  
13 provider. They don't typically identify the carrier. They  
14 don't typically have paid amounts -- the information in them,  
15 but you can do quite a bit of analysis with that data.

16 The limited use data set, typically you have to define,  
17 much like if you're applying for data from Medicare, you have  
18 to go through field by field and say what you're going to do  
19 with that data in your study and the data use board would  
20 review that request, approve that request and monitor that  
21 request to make sure that once you've been given the trust  
22 data, you're actually creating what you said you would do once  
23 the final work product comes out.

24 Several states, including Colorado, I'll show you an  
25 example of that, New Hampshire and others have developed

1 public websites and then many states have just created -- for  
2 static reports on specific issues. They might be looking at  
3 children's health or diabetes or other population health based  
4 reports.

5 So these are just some sort of high level examples of how  
6 the states actually release the data, but I would absolutely  
7 urge the Commission to, you know, include within your  
8 conversations this conversation about data release. It's just  
9 as important as what data you collect in terms of what gets  
10 released.

11 So I would say -- sort of final comments before jumping  
12 into the more detailed slides is that what I've seen  
13 historically is that many of the early states developed their  
14 collection rules and their data release rules at the same time  
15 with all the stakeholders around the table.

16 More recently, we've seen states collect the data and  
17 then once they had it, they then had to go back and have those  
18 conversations about how it would be used and it's pretty  
19 awkward, to be perfectly blunt, and so if you can, within the  
20 Commission or other structures that you've set up, you know,  
21 have that dialog amongst all the stakeholders in the beginning  
22 about collection and release together, my guess is that you'll  
23 have sort of a much stronger level of consensus and hopefully,  
24 a better work product in the end.

25 So if we just jump two slides ahead here to the next one,

1 I put this slide up here because when many of the states  
2 developed their websites and their data collection efforts in  
3 the beginning, they were really geared toward their health  
4 departments, their insurance departments, policymakers, think  
5 tanks, researchers, and that's sort of where it ended in terms  
6 of the sense that it would be used by those entities and what  
7 I found as the data has been released over time is that other  
8 people would like access to it as well, but yeah  
9 (affirmative), purchaser coalitions that represent employer  
10 groups.

11 We have consumer applications that have been developed.  
12 We've seen providers, especially more recently in light of the  
13 Accountable Care Organization and other payment reform efforts  
14 that are being deployed in states and they'd like access to  
15 the data for benchmarking and other purposes.

16 Payers have shown interest in the data and so there's  
17 sort of been an opening up, if you will, of the data to a  
18 broader set of constituents. So what I'll try to do in the  
19 next set of slides here is to sort of categorize by different  
20 types of uses, but also talk a little bit about who actually  
21 was using it, what they did with it and hopefully, leave you  
22 with a better sense of what the benefits are in some of the  
23 different states of using this data.

24 So I'll first start with population health and the reason  
25 I'm starting here is that's where a lot of states sort of

1 naturally gravitate to as they launch their databases. It's  
2 almost like Google Earth, for those of you who have used that,  
3 where you start with sort of the larger picture of the world  
4 and then you zoom into the continents and ultimately down to a  
5 local regional geography and there's a lot of things that can  
6 be done from a population health perspective with the data.

7 It also gives people sort of a sense of what's in there  
8 without going down to say a physician level or a carrier level  
9 or that component. So the next slide that I have up here is a  
10 fairly straightforward heat map and what this is showing is  
11 it's showing COPD prevalence between the Medicaid population  
12 on the left and the commercial population on the right for the  
13 state of New Hampshire and the darker instances that you see  
14 are higher rates and there was a whole series of maps that  
15 were done in 2005 for this particular project for different  
16 conditions and it had (indiscernible - interference with  
17 speaker-phone) in an era of declining budget around public  
18 health and the need to have more of a data-driven approach for  
19 where public health dollars could and should be spent and also  
20 an acute awareness that there were significant differences  
21 between Medicaid and the commercial population in our state.

22 Nowadays, states could also show Medicare data. We did  
23 not have that at the time that this was done, but that would  
24 sort of be a natural progression for this type of map.

25 Similarly on the next slide, this was looking at asthma rates,

1 just shown in a different way. It's shown in a time series,  
2 so 2005 to 2009, and it's also broken out by some different  
3 age spans just to give you a sense that it's not just the  
4 rate, but we can look at age. We can look at category,  
5 geography, et cetera, and this was actually done for some  
6 testimony in Washington around the Clean Air Act a number of  
7 years ago where we wanted to look at some local data, given  
8 our geography being (indiscernible - interference with  
9 speaker-phone) the Midwest and the mid-Atlantic region and  
10 showing, again, that children -- we were seeing an increase,  
11 as well, as in Medicaid, there was sort of a higher rate than  
12 we were seeing in the commercial population.

13 Vermont, on the next slide, has done similar types of  
14 work. Just to sort of bring this together, rates per thousand  
15 and the time series, '07, '08 and '09, for a series of  
16 different disease categories and it's showing prevalence  
17 conditions. Now we're moving, you know, from sort of some  
18 population health to a little bit more into the clinical side,  
19 but you can see again -- you can take this and look at it in  
20 any number of ways.

21 We can also look at specific conditions. The next slide  
22 takes a look commercial versus Medicaid adults. This was  
23 actually done by a group called the Center for Public Policy  
24 Studies and they're an independent think tank who have access  
25 to the data and this was funded through a separate grant that

1 they had applied for.

2 They did a whole series of reports on mental health in  
3 our state and this is just showing the commercial mental  
4 illness diagnosis rates versus Medicaid and as you would  
5 expect, we see higher proportions in the Medicaid population.

6 They also did on the next slide something where they  
7 looked at the number of disorders and they looked at it over  
8 sort of a lifetime prevalence and so within this particular  
9 commercial population and by age category. So what basically  
10 is the prevalence of having one disorder, two disorders or  
11 three or more over the lifetime and so again, this is a  
12 different way of slicing this bit of information.

13 Just a couple more quick examples here in population  
14 health, this next one was done in Utah. They looked at  
15 different geographic areas and this happens to be a blood  
16 sugar screening for diabetes. It's not looking at the  
17 clinical data in terms of what the result was, it's looking at  
18 the claims data to see whether the HbA1c was actually done and  
19 this was part of a report set that they did, looking at a host  
20 of different clinical performance measures and trying to  
21 highlight the public and policymakers for how the state was  
22 doing geographically in a series of conditions.

23 The next one is a benchmarking example. It's the  
24 appropriate medications for people with asthma measure. He  
25 just measures, which folks are probably familiar with,

1 especially if there are payers on the call, are, you know,  
2 typically run using claims data and so this is looking at New  
3 Hampshire data, but then also benchmarking it against the  
4 national benchmark, which is in yellow and again, this was a  
5 website that currently is not operational, but it has got 100  
6 different reports on it that anybody with a mouse could  
7 definitely point and click to.

8 The state is currently switching out its vendor that's  
9 providing the service and so it's in offline mode right now,  
10 but you can see on the left-hand side different report topics;  
11 heart disease and stroke, health risk behaviors, diabetes,  
12 dental access, respiratory diseases, et cetera, you know, all  
13 solid public health topics that have been explored with these  
14 data sets.

15 The next slide comes from an interactive website. You  
16 can point a browser to [www.cohealthdata.org](http://www.cohealthdata.org). It's  
17 Coloradohealthdata.org and this is a site that they rolled out  
18 last fall. They have another major release coming in July  
19 with some additional population health measures and this is  
20 actually showing per capita cost of care for the Medicaid  
21 population in 2011, and then the heat map is showing whether  
22 it's under the state average, 90 to 110% of or greater than  
23 110% of.

24 They have other maps that show specific clinical or  
25 disease indicators and public health measures beyond this

1 cost, but this is the one I was able to grab for today's  
2 presentation.

3 The next slide was a project that was done with CDC  
4 funding. It's a system called HealthWRQS, a web response  
5 querying system and what this is showing is for diabetes.  
6 It's a prevalence report and it's showing diabetes rates for  
7 the commercial population by age group and you can see the  
8 rate per thousand by county.

9 This is Belknap County on the left and then the state of  
10 New Hampshire total on the right and again, there are multiple  
11 disease conditions here. There's also been some work done to  
12 begin to link the claims data with the cancer registry for the  
13 state and we think that there will be a lot more opportunity  
14 in the future to integrate cancer registry and other registry  
15 data with claims data as it becomes more available and robust  
16 and then the last one that I have here under population health  
17 was a study around adverse drug events.

18 I think most folks are pretty familiar with the fact that  
19 this is a major issue. What we did is we used a hospital  
20 discharge methodology for -- that was developed by AHRQ (sp)  
21 and applied it into the commercial population for Maine and  
22 also New Hampshire. This is the Maine data and we were doing  
23 a comparison between the states and this particular report  
24 blinds the carrier, but we were trying to understand were  
25 there differences amongst carriers? Were there differences

1 with another version of this that looks at it blinded by  
2 hospital service area?

3           Ultimately, the report concluded that it's really a much  
4 broader problem than just specific hospitals, you know, or  
5 specific carriers, that it's really more of a community-based  
6 problem. So we looked at rates per thousand. We looked at  
7 the payments and the total discharge information in that  
8 particular study and again -- so this is also something that  
9 was funded by a foundation based out of Maine called the Maine  
10 Health Access Foundation.

11           The next set that I'll go through are a series of  
12 regulatory examples. As I mentioned in the beginning, you  
13 know, a lot of the states started with the idea of having data  
14 available to insurance departments, health departments,  
15 Medicaid agencies, et cetera and there's been quite a bit of  
16 work done in this particular area.

17           The next slide is sort of the first example and basically  
18 what this is, is it's a per member per month rates by age  
19 group and type of service, so ambulance, hospital, pharmacy,  
20 DME, et cetera and trend it and so the New Hampshire Insurance  
21 Department does quite a bit of reporting using the claims data  
22 as they take a look at the carriers that are offering products  
23 within the state, but also just at some of the highest level  
24 that this is, to try to get a sense of where things are and  
25 this is broken out by age.

1           They have other reports that are a time series so that  
2 you can take a look at either by age or by type of service.  
3 Our Medicaid program has also used the data on the next slide  
4 for payment benchmarking purposes. I know every state in the  
5 country says that its Medicaid rates are the lowest. New  
6 Hampshire's actually, I think, almost are in most cases the  
7 lowest and so what the policymakers asked for a few years ago  
8 was a study to figure out well, how bad was this, and they  
9 were able to take a look very rapidly at what was being paid  
10 to the Medicaid providers as compared to what the fee  
11 schedules were for the commercial population and have they had  
12 the Medicare data in this database, they could have thrown  
13 that up as well. They were able to pool that through separate  
14 fashion, but again, very quickly, this type of reporting is  
15 available.

16           The next slide is a system that unfortunately is down  
17 while they're swapping out the vendor for the state, but the  
18 idea was to build a front-end interface so that anybody with a  
19 mouse could get a report and it breaks it out by Medicaid. It  
20 breaks it out by commercial and on the left-hand side, you'll  
21 see different chronic diseases, diabetes, mental health,  
22 cardio vascular, utilization and cost reports by category of  
23 service, by payment category, specifics of pharmacy, emergency  
24 department, other high-dollar, high utilization services.

25           There are enrollment reports and then you can select the

1 time period. You can select an eligibility group. You can  
2 select a service area geographically, hit go, and it would  
3 basically go ahead and produce a report. So this is the tool  
4 that was used to create one of the asthma reports that I  
5 showed in the beginning of this slide deck and again, was able  
6 to just with, you know, three quick reports to pull a time  
7 series by age of asthma prevalence, as an example.

8 What Colorado has done, if you go to their website, is  
9 you'll see a much fancier user interface than sort of the  
10 plane Jane one you see here and the goal that they have,  
11 really, is to make the data quite publically available to  
12 folks as much as possible and I think that's sort of a trend  
13 that we'll see more from states. We're seeing it more in the  
14 RFP's that they're issuing to vendors for services.

15 On the next slide, in Vermont, the system is overseen by  
16 -- it's essentially their insurance department, although it  
17 has a much longer name than insurance department. It's called  
18 BISHCA Insurance Banking Regulations and they've been doing a  
19 lot of work, both with the claims data and also with clinical  
20 data and one of the things that they've been trying to do as  
21 part of their health reform efforts of medical (indiscernible  
22 - voice lowered), clinical care, payment reform is to try to  
23 first and foremost, identify the provider geographies that  
24 have the higher cost, high quality care and then figure out  
25 what's different about those and then try to translate that

1 down into projects on the ground to move everybody into that  
2 upper right-hand quadrant that you see here and there's a 25-  
3 page report behind this graph that goes along with this. So  
4 this is just one example of what the state of Vermont has been  
5 doing there.

6 The next slide is something else that Vermont produced.  
7 About six years ago, the northern New England states were  
8 coming online at about the same time and they said, "Wouldn't  
9 it be great if we could eventually compare our data across  
10 state lines?"

11 So we worked hard to make our data collection and release  
12 practices similar and this was something that was done about  
13 three years ago, three summers ago and it was a report looking  
14 at a whole host of different types of services that have been  
15 delivered, a series of heat maps that were done and you can  
16 see it again, a wide range of rates of MRIs in this particular  
17 example from 90 per 1,000 to 46 per 1,000 over in Maine, but  
18 it was really the first time that we were able to bring these  
19 data sets together across state lines, across payers in one  
20 integrated fashion and I think that's really one of the major  
21 points about the all-payer claims database is that it allows  
22 you to very rapidly look at things across multiple carriers  
23 now and multiple geographies, as we've shown here.

24 It may be less of an issue in Alaska, given where you're  
25 located, but something that many of the states are looking

1 toward, especially if there is patient migration from one  
2 geography to another, which actually is outlined on the next  
3 slide.

4 We were trying, in 2006, to get some traction around  
5 health information exchange and there was a lot of concern  
6 from our hospital communities that if they began to share data  
7 electronically, that they might be losing patients to their  
8 competitors in other service areas.

9 So we said, "Well, let's take a look at the  
10 administrative data and see what's happening today." So on  
11 the left-hand side of the map, you'll see inpatient services  
12 and on the right, you'll see outpatient services and the  
13 darker into purple that you see is basically more patient  
14 migration leaving that community, going to another community  
15 for services.

16 In the top part of our state, we have more moose than  
17 people and so it makes sense that you wouldn't be getting a  
18 lot of cardiac tests done in the northern part, but also in  
19 the lower part of the state, we are almost a suburb of Boston  
20 and it was surprising at first to see how much mobility was  
21 taking place from the seacoast part of our state and down into  
22 to Boston for services.

23 At the same time, what we were also able to show through  
24 another set of maps was care coming into the communities and  
25 so while you see -- we clearly saw care going out of a

1 community, we often saw reciprocal care coming back into a  
2 community and from those maps, we're able to give them to the  
3 folks building the health information exchange and say, "If  
4 you're going to start to connect the communities  
5 electronically, here's where people are moving back and forth  
6 already today and they're carrying their records by hand or  
7 you're faxing them. So let's look at connecting those folks  
8 electronically."

9 So not a use we ever would have anticipated for the all-  
10 payer claims database, but it became very powerful in a very  
11 simple way to figure out this issue of patient migration.  
12 We've also used similar types of reports to look at care being  
13 received in other states by illness burden and also to look at  
14 care in the pharmacy world that's going outside the state due  
15 to mail order.

16 On the next slide, I've got another example here of price  
17 variation and we have in our state about a 70% differential  
18 between the lowest priced hospital facility and the highest  
19 priced and this has been true for about 20 years now and a few  
20 years ago, our insurance department started to use this  
21 database to do some annual reporting in this area, which  
22 ultimately led to -- on the next slide, you'll see the  
23 description, but it was the creation of a health plan designed  
24 to be offered in the small group marketplace.

25 Four carriers participated in it when it was developed in

1 '09. It's a tiered network based with hospital deductibles,  
2 expanded preventative care and the goal here was to offer it  
3 at a rate that was 10% of the prior year's median wage. So  
4 how do they offer a product in this small group marketplace  
5 that's also less expensive and so they were able to use the  
6 data from the prior slide to help determine the rankings for  
7 the facilities and manage that tiered network.

8 About half of them -- the hospitals are in rural areas  
9 and so there was sort of an additional consideration taken for  
10 those particular facilities, but again, an example of using  
11 the data to drive policy.

12 The next slide is an example of an annual report, just a  
13 subset that gets done, also by the insurance department,  
14 looking at carrier discounts and you can see they're pretty  
15 similar. There's not enormous spread, although some between  
16 them and again, this is for the HMO line of business and they  
17 break it down by the other lines of business, as well.

18 Then the final report in this section, I have to jump  
19 through goes back to that issue of in-state and out-of-state  
20 spending and this was an eye-opener, I think, for the  
21 marketplace, as well as the policymakers when it came out.  
22 What it shows here is by carrier, the percentage of services  
23 that are remaining in-state New Hampshire versus going to  
24 Massachusetts, both the percentage of membership and then also  
25 looking at it in terms of percentage of dollars and so roughly

1 85% of it dollar-wise is staying in the state and about 10 to  
2 12 going outside.

3 What you'll see in the box in the middle right for  
4 Harvard Pilgrim Health Care is that there's an illness burden  
5 score on the far right and so the patients going into  
6 Massachusetts have a higher illness burden. It means that  
7 they're sicker patients. If they're costing about \$1,000 less  
8 per patient on a pay basis, this is not charted, it is actual  
9 payments, and when more research was done looking into this, a  
10 lot of it had to do with the fact that because there's so much  
11 more competition in the Boston marketplace, that Harvard  
12 Pilgrim and some of the other carriers were actually getting  
13 better contractual discounts with the facilities, even though  
14 the patients that were being seen were sicker patients in  
15 terms of their illness burden.

16 There's also a theory, too, that some of those providers  
17 are doing -- the throughput is just so much higher for some of  
18 the higher risk procedures that they're actually better at it,  
19 but it was, again, sort of the first time we were able to use  
20 data like this to begin to start to take a look at, you know,  
21 how the market itself is actually behaving.

22 The next few slides I'll jump through are on the consumer  
23 space. This is one that's a little controversial and the  
24 first slide that I'll throw up with the website our insurance  
25 department built in 2006. They built that as a response to

1 the price variation curve that you saw a few slides ago and  
2 also to the response to incredibly high premiums and a shift  
3 into high deductible health plan offerings that we're seeing  
4 as a way to provide information to consumers should they want  
5 it.

6 So essentially, what the website allows you to do is  
7 select a procedure, what carrier you have, what product you  
8 have and what co-pay or co-insurance or deductible that you  
9 have and then it will tell you, based upon pay claims  
10 information, what your estimate is, what the insurance  
11 estimate is and then the total payments and again, for some  
12 procedures, there's as much as a 10,000-dollar variation  
13 between surgery centers to hospitals and in between.

14 What it doesn't do, is it doesn't address the issue of  
15 quality and I think that this is a really key point and I  
16 think it's problematic when we start showing data like this to  
17 consumers and we don't have a quality component. Even if we  
18 were just to show the number of procedures that was done or we  
19 were to show readmission rates, you know, those are things  
20 that can be calculated out of the claims data that would be  
21 fairly straightforward.

22 We also think, you know, based upon some research that  
23 has been done that consumers don't look for this data until  
24 they actually are in the middle of the emergency. So you  
25 know, how truly shoppable are some of these procedures? You

1 know, if it truly is elective, you know, yes, most likely, but  
2 if it's a non-elective procedure, you know, you're going to  
3 have the ambulance take you to the closest facility if you're  
4 having a heart attack.

5 So I think, that you know, while there is a lot of buzz  
6 right now around providing information to consumers, I don't  
7 think anybody has done it particularly well at this point in  
8 time and I don't think people really necessarily know what it  
9 is that consumers actually need yet and I think there's more  
10 work to be done in this area.

11 The next slide's an example of a website that  
12 Massachusetts rolled out. I think it was in '07, about a year  
13 after the New Hampshire site and they took a little bit of  
14 different tack where you can see quality ratings and then a  
15 cost rating and they're done in the form of this star system  
16 for quality, so one, two, three-star, and then a one, two,  
17 three-dollar sign for cost versus the actual dollar amounts  
18 and again, it's a different way of presenting the data.

19 I like the fact that they are bringing quality and cost  
20 together, but unless you're able to drill down to the next  
21 level to find out well, what was the price, or you know, what  
22 was the readmission rate, or what was the nosocomial infection  
23 rate, you know, how useful it, you know, really going to be?

24 A lot of the carriers that we've seen have done, you  
25 know, their own websites for their consumers and they actually

1 go down to that level of detail. Products like (indiscernible  
2 - voice lowered) which is purchased from (indiscernible -  
3 voice lowered) and others, so I think we're at a very nascent  
4 stage with the APCD in terms of consumers.

5 The last slide, this is taken out of a report from Maine  
6 and it's data that's been provided through an employer  
7 coalition to consumers for years in different formats and  
8 this, again, is a price variation slide for colonoscopies and  
9 there's actually -- for certain procedures in Maine, there's  
10 one large supermarket chain and they literally will pay for  
11 the family to be put in a limo to go to Boston for the  
12 procedure to be done and they put that family up at the hotel  
13 to be with their loved one.

14 They get them home two days earlier for some of the  
15 procedures, say a hip, than if it were done at some of the  
16 remote outposts in Maine and they've got higher outcomes and  
17 it's thousands of dollars less. So you know, so this is  
18 really, I think, the (indiscernible - interference with  
19 speaker-phone) that you know, there's a lot of information,  
20 but you really need to understand it and then determine, you  
21 know, what are you going to do with it, you know, from a  
22 policy perspective or from other perspectives.

23 To that point, the next few slides just talk about  
24 purchasers and I think this is pretty exciting in terms of  
25 what we're seeing in several parts of the country around

1 purchasing coalitions looking for data. Many of them have had  
2 it for their own self-funded populations for years, like the  
3 state of Alaska, it might be GE or Raytheon or some other  
4 organization, and they're using it for different purposes.

5 The first example is a report card where it's merging  
6 data. The far right-hand column, that cost index is pricing  
7 variation data from the APCD. The other data are coming from  
8 data sets, such as CMS Quality Compare, but basically it's  
9 just a ranking by facility and this is, again, given to about  
10 130,000 consumers that belong to this particular coalition.

11 Our sister state in Maine produces something similar for  
12 their coalition and I think when a lot of the purchasers start  
13 out, they go right to cost, but what I've seen more recently,  
14 and is shown on the next few slides, is we're finding  
15 purchasers, especially the larger ones, seem much more  
16 interested in the overall employee health and wellness and  
17 understanding that they want to retain the employees for a  
18 long period of time, that they're willing to think about the  
19 health of that employee over a long period of time and this is  
20 especially true amongst public purchasers, such as states,  
21 universities and school systems.

22 So this first one, a little busy, but it's showing over -  
23 - it's a time series of prevalence of various conditions, so  
24 back, depression, diabetes, asthma, coronary heart, and  
25 there's corresponding data sets that show the pricing

1 associated with these.

2 The next one shows preventive rates by employer versus  
3 state totals. So the blue, red and green bars are individual  
4 employers that are in the coalition and how they stack up  
5 against one another and the purple bar on the far right of  
6 each of the series is the state total and this is something  
7 that we hear increasingly from the employers (indiscernible -  
8 voice lowered) very large ones, such as CalPERS in California  
9 or the Pacific Business Group on Health, whereby they've been  
10 able to benchmark against themselves, but they don't have  
11 necessarily the benchmark against the broader population.

12 If they're an individual employer with a large, you know,  
13 carrier behind them, they might be getting that at the self-  
14 funded account. So let's say it's a Blue Cross plan, they  
15 might be providing, you know, benchmarking information, but  
16 they're not able to see how they necessarily stack up against  
17 the entire state as there are multiple carriers, you know,  
18 within the state, but increasingly, we're seeing the  
19 purchasers trying to use this information in ways that can  
20 better help them augment or update their own health and  
21 wellness programs to maintain the health of the earth, so to  
22 speak, within their populations and one of the things that  
23 they're also finding, my final note on that, is just the fact  
24 that it's not always the employee and a lot of purchasers have  
25 spent a lot of money funding programs for employee incentives,

1 et cetera, but often times, it might be a spouse or a child,  
2 who actually is the one with the condition and through some of  
3 this reporting, they've been able to dig down into the  
4 subscriber, family members and sort of tease that out in terms  
5 of trying to understand, you know, where some of that should  
6 be targeted to.

7 The next slide is very straightforward. It's just a high  
8 level pharmacy volume, brand, generic, specialty between 2010  
9 and 2009, and it's sort of a lead-in to the next two, which  
10 are actually -- I took them from Utah, but they are the drug  
11 spending and I didn't talk too much in the beginning about  
12 this.

13 In addition to health claims, all the pharmacy claims are  
14 available, as well as dental, for most states and pharmacy is  
15 a pretty rich data set, one that I don't believe is tapped to  
16 the degree that it will be tapped, but significant volumes of  
17 data passing through this.

18 This particular one shows the top 10 classes by the  
19 number of prescriptions written and the next one shows the top  
20 10 drug classes by the total cost and so it's essentially the  
21 same top 10 report, but one's by number of prescriptions  
22 written and one by class and again, you can drill down on each  
23 one of these if you want to figure out, okay, within ulcer  
24 drugs, what are the top five drugs being written there?

25 Are they brand? Are they generic, et cetera, and again,

1 a lot of information in pharmacy and the pharmacy data is used  
2 for things, such as episode groupings and other analytics,  
3 risk adjustment. So there's lots of reasons for capturing it,  
4 but just the raw data itself has quite a bit to it.

5 The last sort of category that I'll go through and then  
6 open it up for questions is just this topic of health care  
7 reform and APCD is on the next slide and health reform are  
8 really being looked at from a lot of different perspectives.

9 Clearly, population health evaluation, while people think  
10 reform is happening in D.C., it's really happening, I believe,  
11 in the states and boast their own efforts, as well as what's  
12 trickling down from Washington, and really understanding the  
13 accountability around population health is going to be  
14 critical, whether it's through payment reform or other  
15 mechanisms.

16 We talked about prevalence measures. We've seen examples  
17 of utilization and spending quality measures. This notion of  
18 risk stratification, I'll show some examples of that by  
19 chronic conditions, so what percentage of your population has  
20 one chronic condition? What percentage has two? What  
21 percentage has three or more?

22 You know, those are folks, that you know, clearly need to  
23 be targeted because that's where a lot of the spend is, as  
24 you'll see in an upcoming slide. Rate review audits is  
25 something that several states are looking at around their

1 health insurance exchanges.

2 How do we engage consumers? What questions do we ask?  
3 How do we engage employers who are footing, at least on the  
4 commercial side, you know, the bill? These are all things  
5 that states are looking toward their APCDs to help them start  
6 to address.

7 This particular slide was done a few years ago. It was a  
8 result of a two-year primary care center medical home pilot  
9 and it was done in nine physician practices, especially the  
10 slide right before this, and what we did was looked at the  
11 nine practices before the medical home pilot took place and  
12 then afterwards to try to get a sense of whether or not the  
13 money that the carriers had spent in that pilot had paid off  
14 and if you just jump back to the prior slide here, basically  
15 what it shows is that in the baseline period, we were running  
16 at about \$240 per member per month and dropped to about \$150  
17 per member per month after that and in terms of the non-  
18 medical home sites, went from 240 to about 222.

19 So you know, the ability to sort of use this data for  
20 large-scale retrospective studies and evaluation of specific  
21 interventions in the healthcare system is really the point of  
22 this particular slide.

23 The next one is similar to the one that showed that heat  
24 map where we listed it for the health information exchange,  
25 but what Vermont did in this one is they looked at the

1 Burlington Primary Care service area to try to understand the  
2 folks that were migrating into that particular service area  
3 and what's a little bit different about the data underlying  
4 it, is it's not just the all-payer claims data set, but they  
5 had primary care patient rosters.

6 They had a registry that was imbedded within their health  
7 information exchange, as well as licensure data to develop the  
8 provider database underlying all of this and so it was one of  
9 the earlier examples a few years ago of starting to take, not  
10 just the claims data by itself, but merging it with different  
11 data sets.

12 The next slide comes out of an accountable care program  
13 also in New Hampshire where the system, this particular  
14 process, is looking at for the sites called ACP, Accountable  
15 Care Program, sites versus the state totals and looking at the  
16 spend, as well as the number of people involved.

17 So you can see for those patients with no chronic  
18 conditions, it was \$281 for these sites and 293 for the larger  
19 state and then with one chronic condition, with two or more  
20 chronic conditions, and then everybody, what it looks like,  
21 and clearly, what you can see here is if you add chronic  
22 conditions, it gets more expensive, but overall, the  
23 accountable care pilot sites had a lower per member per month  
24 cost, not by much in all cases, but overall, it was lower than  
25 the overall state. So again, for evaluation purposes, this

1 was done.

2 Similarly, on the next slide, looking at emergency  
3 department utilization for the same group of folks, that was  
4 with zero encounters, one encounter, two to four, or five or  
5 more encounters, and again, you can look at the overall per  
6 member per month rates and this is comparing the commercial  
7 population to the Medicaid population. So it's a little bit  
8 of a different comparator and again, you'd expect to see a  
9 different spend in one versus the other.

10 What's interesting here is that the Medicaid spend is  
11 less, although the rates are a little bit higher due to the  
12 fact that Medicaid doesn't pay as much in terms of its fee  
13 schedules.

14 Then the next one comes from Utah, also again, chronic  
15 conditions and they did some very large population health  
16 studies in 2009, and they took their entire commercial  
17 population and put it through a grouping software to try to  
18 take a look at where were the dollars being spent in terms of  
19 the proportion of a patient with different chronic conditions  
20 and so the highlighted pink bars in the middle, Category 5 and  
21 6, these are folks with one or two significant chronic  
22 conditions and 21% of Utah residents comprise that, yet it's  
23 51% of the total dollars that are actually being spent.

24 So if we're thinking about public health and we're  
25 thinking about health reform, payment reform efforts, et

1 cetera, you know, clearly, folks with chronic conditions are  
2 key. It also begs the question about folks that are pre-  
3 chronic. So if I'm a 45-year-old male and 10 pounds  
4 overweight and my glucose is a little high, I'm not diabetic  
5 yet, but I might be headed in the direction, what can we do to  
6 head me off? You know, that's sort of another kind of major  
7 issue that people are starting to look at nationally, as well  
8 as with some of these data sets.

9 Then the last two slides I'll pop up here, this is  
10 something called episode treatment groups and what these are  
11 is they take, for specific conditions, all the services  
12 associated with that condition and they group it into what's  
13 called an episode and this software has been around for  
14 decades and I worked in the payer world in the '90's. We used  
15 it quite a bit with our populations and this is looking at  
16 ETGs for benign conditions of the uterus and what is shows is  
17 three different scenarios, if you will.

18 If there's a hysterectomy, which is the green column,  
19 other types of surgical interventions, and no surgery, and  
20 what you'll see at the bottom is the payment amounts in terms  
21 of what it costs depending upon which path goes down in terms  
22 of treatment, but you can also see in the middle the different  
23 types of services, CT-scan, ultrasound, biopsies, et cetera,  
24 and the percentage of time that they're actually performed.

25 So if I am a hospital system entering into an accountable

1 care, you know, payment methodology, using retrospective  
2 analytic tools such as this to understand, you know, where are  
3 there areas of opportunity within my particular population, to  
4 think about how I might want to redesign, if you will, the  
5 clinical processes and clinical practices in order to, not  
6 only shift the outcomes clinically, but also shift the  
7 outcomes in terms of finances.

8 These types of tools are very straightforward. This data  
9 was run on the entire commercial population. So you can very  
10 easily slice it by carrier. You can add it to compare  
11 Medicaid to Medicare to commercial, et cetera, you know, with  
12 literally just some very small tweaks in the software, because  
13 again, all the data for the entire population is within the  
14 database.

15 Then my final slide, again, increasingly what we're  
16 seeing with the states is emphasis, both on the health  
17 information exchanges, which are bringing the clinical data  
18 sets together by connecting electronic health records and also  
19 health information and -- I'm sorry, insurance exchanges,  
20 which are being built to move toward 2014 and the marketplace  
21 changes and different states are looking at how their APCDs  
22 are going to interface with these.

23 So for instance, in Delaware, they're looking at bringing  
24 the claims data into their health information exchange. We  
25 have states like Connecticut that are bringing it into their

1 health insurance exchange for rate review and risk  
2 adjustments. We have states like Minnesota that are going to  
3 take provider profiling information and make it available to  
4 the consumer as they're picking their health plan and picking  
5 primary care physicians, et cetera, to go with that health plan  
6 selection and their HIX, so different integration points.

7 It's sort of a little more detailed from one of the  
8 earlier slides' diagrams before I went into the specific  
9 examples, but this is really where I think a lot of the states  
10 are focused right now around APCDs. They're looking at the  
11 other systems that they have, the other systems that need to  
12 be supported and they're looking at, you know, what's the  
13 return on investment? How are they going to go ahead and make  
14 these systems sustainable, and the conclusion that many of  
15 them are reaching is that these systems need to be  
16 interoperable. They need to get benefit, not just through one  
17 platform, but platforms coming together and being integrated.

18 So with that, I will be quiet and happy to take any  
19 questions that folks have. Hopefully, this gave you a little  
20 bit of insight in terms of what some of the states are doing  
21 with the systems. We have more information on our website and  
22 I was telling Deborah that in August, we'll be launching a  
23 completely new website with examples such as these and others  
24 that we've gathered to make it easier for commissions, such as  
25 yourself, to really get a sense of what states are doing in

1 sort of a case study fashion with the all-payer claims  
2 database. So I really appreciate your time this morning and  
3 would love to answer any questions or try to answer any  
4 questions that you might have. Thank you.

5 CHAIR HURLBURT: Thank you very much, Patrick. Yeah  
6 (affirmative), with our late start and our schedule, we only  
7 have about eight minutes left, but I think, Tom, you had a  
8 question.

9 COMMISSIONER HARRELL: Mr. Miller, this is Colonel  
10 Harrell. I'm a physician here with the United States Air  
11 Force. So this morning, we took some comments from a panel,  
12 two members of which are providers, and there's no question  
13 that the APCDs can provide reams of data that can be sliced  
14 and diced in multiple ways and it appeals to our human nature  
15 to have information and I'm also convinced that the  
16 information can, in fact, be valuable. So it's not just data,  
17 but it actually is information particularly as it would impact  
18 quality care and outcomes, but I'm very curious, in your work  
19 with this and promoting it, have you taken surveys from  
20 providers as to the impact that this has on the  
21 provider/patient relationship?

22 We heard that this morning, because no matter how we  
23 would implement something like this, it will drive increased  
24 documentation, which will drive an increased burden, which  
25 will adversely affect the doctor/patient relationship. So

1 have you taken focus groups regarding the impact of this in  
2 those states where it's been employed on the perception of  
3 care as it relates to the relationship between the provider  
4 and the patient?

5 MR. MILLER: I haven't -- thanks for the question, first  
6 of all. I have not seen any states specifically look at  
7 provider/patient relationships. I also haven't seen any of  
8 the employer coalitions, many of which have been doing this  
9 type of reporting to their employees much longer than -- since  
10 APCDs were actually -- have been around and so I haven't seen  
11 that. I'd be happy to check with folks on our listserv to see  
12 if anybody else knows of anything in that area.

13 I think most of this doesn't typically get down to the  
14 patient level, while some of the (indiscernible - voice  
15 lowered) the consumer websites, as an example, have been  
16 around for a few years, the utilization of them is really  
17 quite, quite low.

18 I think one group that we might want to extend your  
19 question to is out of Wisconsin. It's called WHIO, W-H-I-O,  
20 and they're a voluntary APCD. It's not a state mandated  
21 platform. They show no payment information, but what they do  
22 is they provide data directly to providers. So they'll get a  
23 group of obstetricians or different specialties together to  
24 take a look at data to look at how they might be able to  
25 change practices of care and so I'd be happy to shoot them the

1 question, your question, and see if they have anything that I  
2 can circle back to (indiscernible - interference with speaker-  
3 phone).

4 COMMISSIONER HARRELL: Thank you.

5 COMMISSIONER URATA: This is Bob Urata. I'm a family  
6 physician. In all your years working with this, have you seen  
7 any unforeseen or seen negative consequences to the consumer?

8 MR. MILLER: About cost?

9 MS. ERICKSON: It was whether you've seen in all the  
10 years any unforeseen negative consequences from the consumer's  
11 perspective.

12 MR. MILLER: Sure. I haven't seen anything from the  
13 consumer perspective to date. The -- there was a study that  
14 was done after the New Hampshire health cost consumer website  
15 went live about two years later and it was trying to  
16 understand the impact to the overall health trend and  
17 basically, what it showed was that the overall trend stayed  
18 the same, but there were variations in pricing for specific  
19 procedures that had changed as providers and insurance  
20 companies were actually using the website for negotiation  
21 purposes, so -- but there was nothing that was sort of  
22 negatively resulting in sort of patient issues that we saw  
23 from that.

24 CHAIR HURLBURT: Jeff.

25 MR. MILLER: Most (indiscernible - voice lowered) still

1 at the level, I would say, of the population health view.  
2 Yeah (affirmative), there's still the kind of the 20,000 or  
3 30,000-foot view versus getting down into Hospital A versus  
4 Hospital B. I think that's what a lot of people want to talk  
5 about, but I don't think most states are there, to be  
6 perfectly honest.

7 COMMISSIONER DAVIS: Mr. Miller, this is Jeff Davis and  
8 I'm a health insurance executive. Thanks for your informative  
9 presentation. You've shown us a lot of examples of  
10 interesting data, but it's like, wow, that's interesting. I  
11 wonder why that is? Can you give us some concrete examples or  
12 times where the "aha" has turned into more specific knowledge  
13 and turned into action that's then changed something in the  
14 real world, either resulted in care being improved or public  
15 health being improved or costs being reduced? I appreciate  
16 that, if you could. Thank you.

17 MR. MILLER: Sure. I think for the most part what we've  
18 seen have been in the area of population health and I think  
19 also in some of the employer coalitions. In terms of public  
20 health, I think sort of the redirection of dollars, knowing  
21 where to put the dollars based upon the (indiscernible - voice  
22 lowered) approach, I think has been one of the key "ahas" that  
23 we've been able to see.

24 I think, also, in the employer coalition space, it's been  
25 realizing, that you know, this really isn't all about short-

1 term dollars. This is about the long-term health of our  
2 employees. How do we take our existing health and wellness?  
3 How do we augment it with data? How do we work with our  
4 carriers to basically create a healthier, happier employee? I  
5 think there are examples of that.

6 Then I think most recently, what we're finding with our  
7 accountable care program with the 11 participating provider  
8 organizations and the four carriers is that they're realizing  
9 if these new payment reform models are to actually be  
10 successful, that there needs to be an incredibly robust data  
11 information store available and that it cannot just be from a  
12 single carrier, that it has to be cross-carrier, because that  
13 carrier may not be representational of their entire book of  
14 business as a provider and so I think there's a relationship  
15 and an understanding here of sort of the integration of the  
16 points between the providers and the payers and having to have  
17 sort of a shared data platform or at least a shared data  
18 understanding, if you will, and I think what that's doing is  
19 it's creating learning networks and other conversations that  
20 four or five years ago just were not even possible in our own  
21 state.

22 When our system started in 2006, there wasn't a single  
23 carrier, nor I would probably say a provider that was really  
24 that excited about it and today, while I still don't think a  
25 lot of carriers, because it really is an unfunded mandate on

1 the carriers to provide the data, but there's an understanding  
2 that there is a shared vision of payment reform and then data  
3 is fundamental to that and so I think it's creating  
4 conversations that are leading to that transformational change  
5 that we're looking for.

6 You know, five years from now, hopefully, I'll have, you  
7 know, a lot more to say about that, but that's sort of the  
8 direction we're seeing in the states that have been at it the  
9 longest, but this is not a one-year, two-year, three-year  
10 return on investment.

11 This is a strategy. You know, is information for the  
12 state of Alaska important since Alaska makes decisions no  
13 matter which part of this constituent map you're a part of? I  
14 think that's really the question to ask.

15 COMMISSIONER DAVIS: Thank you very much.

16 CHAIR HURLBURT: So maybe just to follow up on the last  
17 point and to paraphrase it a different way and see if it's  
18 incorrect, the data that you presented could be of benefit to  
19 an individual consumer, particularly in a consumer-directed  
20 health plan where they have more skin in the game.

21 It would be of value to employers, even as big as a few  
22 thousand enrollees, where they don't have that population  
23 based data, but your bigger payers, like your Anthem or your  
24 Harvard Community Health Plan, where they've got 100,000 or a  
25 couple hundred thousand lives and they can generate all this

1 data themselves and they have been, basically they're doing it  
2 because they have to and because they're being good citizens,  
3 but you're not hearing that it is being an advantage to them  
4 at this point? Is that correct?

5 MR. MILLER: We're definitely seeing the larger plans  
6 providing a lot of that information and I think it's important  
7 that they do so, but it's within their four walls. You know,  
8 if you have to be a member of that plan first to get access of  
9 those tools versus having something that's external and that's  
10 available to the general public and also providing data to  
11 those who don't have insurance. Now, maybe theoretically,  
12 after 2014, I'll say a little facetiously, "Nobody will have,  
13 you know, will lack insurance anymore," but there will still  
14 be that group of individuals that either chooses not to or  
15 doesn't have it for whatever reason and to have some way for  
16 them to take a look at what's happening in the marketplace or  
17 as a purchaser, maybe it's a small group.

18 We have another website available from our insurance  
19 department where you can actually take a look at sort of a  
20 benefit ratio of the premium charge versus the benefits  
21 provided versus the claim that's paid out to get a sense of,  
22 you know, if I'm going to spend \$1,000 a month on this  
23 particular plan, you know, is it relevant to me or am I  
24 getting as much of a benefit out of it, as if I was spending,  
25 you know, \$1,000 a month on this other plan and so I do think

1 that there clearly are details, pieces of information that the  
2 plans will absolutely have to provide one phase, you know,  
3 capture that consumer or capture that employer, but there is  
4 still information that's I believe valid to be providing to  
5 the marketplace as folks are making purchasing decisions or do  
6 not have coverage.

7 CHAIR HURLBURT: Okay.

8 MR. MILLER: I don't know if I answered your question or  
9 made it worse.

10 CHAIR HURLBURT: Yes, well, thank you very much, and we  
11 are going to need to move on. I'm sorry we had technical  
12 problems because.....

13 MR. MILLER: (Indiscernible - interference with speaker-  
14 phone) what I want to offer to the Commission is if you have  
15 any further questions in the coming weeks or months or days,  
16 please, you know, route them through Deb, have her contact me.  
17 I'd be happy to get back to you. If you want to set up any  
18 sort of a follow-up call for Q/A, maybe after you've thought  
19 about it, et cetera you know, I'd be happy to do that as well,  
20 given that we have run out of time. So don't hesitate. We're  
21 here and happy to help in any way that we can.

22 CHAIR HURLBURT: Thank you. I think we will be taking  
23 you up on that and we appreciate it very much.

24 MR. MILLER: Okay. Well, enjoy your day. I hope the  
25 weather is beautiful and I'm sorry I'm not there in person,

1 but I will get there next time.

2 CHAIR HURLBURT: Maybe another time, thank you, bye.

3 MR. MILLER: All right.

4 UNIDENTIFIED FEMALE VOICE: Thank you, Patrick.

5 MR. MILLER: Take care, everybody. Have a good  
6 afternoon.

7 UNIDENTIFIED MALE VOICE: Thanks.

8 CHAIR HURLBURT: So we'll take a break for lunch now. If  
9 the folks in the public section could let the Commission  
10 members go first. I'm sorry.

11 UNIDENTIFIED FEMALE VOICE: And Dick and John.

12 CHAIR HURLBURT: And Dick and John, so that we can be  
13 ready -- probably Dick and John should go first or you'll have  
14 to talk with a mouthful, but so we can be ready to go right at  
15 12:30 sharp. Thank you.

16 12:03:19

17 (Off record)

18 (On record)

19 12:29:12

20 CHAIR HURLBURT: Commission members, if we could go ahead  
21 and have a seat around the table and please continue to eat  
22 your lunch. If you need to go get some more food, if it's  
23 there, you're welcome to. For the public comment period,  
24 which will be coming up at 1:30, if the public members who are  
25 here, if you want to comment, if you could sign up on the

1 sheet in the back of the room. For anybody that's on the  
2 phone lines, we'll also give you the invitation and the  
3 opportunity to comment during the public comment period at  
4 1:30.

5 For the next hour, we want to consider the Alaska  
6 Hospital Discharge Database Status. We'll get into probably a  
7 little bit what the discharge database is. The non-uniformed  
8 less than full participation in Alaska, but what the benefits  
9 of that is, it is another source of data. It's somewhat  
10 related to an all-payer claims database, but very different in  
11 many other ways. So Dr. Richard Mandsager, who is the CEO of  
12 Providence Alaska Medical Center, and Mr. John Lee, the CEO of  
13 the Mat-Su Regional Center, have come and are providing the  
14 panel for us and thank you both very, very much for coming and  
15 Dick, if we could start with you, I guess, on the list,  
16 please?

17 MR. MANDSAGER: So, I'm Dick Mandsager. How many  
18 (indiscernible - too far from microphone).

19 UNIDENTIFIED MALE VOICE: Push the button, Dick.

20 MR. MANDSAGER: Okay, is this better? I'm Dick Mandsager  
21 and I'll go first for a few minutes and I think I'll reflect  
22 back to 2005/2006 when the current version of the Alaska  
23 Discharge -- Hospital Discharge Database got started because I  
24 was working at the state at that time and there was a lot of  
25 discussion about mandatory versus voluntary.

1           There was a lot of discussion about scope and depth and  
2 breadth of the database. The end result of it was that it was  
3 decided to use ASHNHA, the State Hospital and Nursing Home  
4 Association, as what I'll call a facilitator or contractor  
5 mediator to receive the data and to subcontract with a company  
6 in the Midwest that has done this for a lot of states over the  
7 years and it started somewhere around that time and has  
8 continued to this point.

9           Just a comment or two about what's in it, it includes  
10 discharge data. It includes some demographic information, so  
11 Zip codes. Where are people from? It applies to hospitals.  
12 So it's really discharge data.

13           There have been a lot of discussions over the years about  
14 widening it, emergency rooms, ambulatory surgery centers, and  
15 you can go on and on and on. So like the previous discussion  
16 before lunch, how wide you make a data set, what's in it, in  
17 my view, really should go to what you intend to use the data  
18 for and what information is going to be generated by receiving  
19 data.

20           So here's my take on it, on the current state of Alaska  
21 and you're just going to get my point of view. I think that  
22 there's this minimal database that is useful to the state for  
23 a couple of reasons and they pertain to a certificate of need.  
24 If you're going to -- if the state's going to make decisions  
25 about -- capacity decisions, then there should be some basic

1 data available to make that decision.

2 There also is some data that's useful for population  
3 health. So for communities to have some information over time  
4 about where did their folks from their community go for care?  
5 What are the basic types of care they either get in their  
6 community of go some place else for, and again, that then can  
7 also go wide and deep, depending upon how much you want to do.

8 I think that hospitals should report. I think ambulatory  
9 surgery centers should report. I think imaging providers  
10 should report and probably long-term care providers and then  
11 if that's the who, then the big question, the next question  
12 would be what? I think we should have some volumes, inpatient  
13 and outpatient. I think ED (sp) volumes should be included,  
14 surgery volumes should be included, principal diagnosis code,  
15 length of stay and then some basic demographics, but if we're  
16 going to do it, there's got to be capacity to turn that data  
17 into information and I think that's been weak in our stateside  
18 and that there needs to be analytic capacity to use data, not  
19 just to receive it.

20 Up until now, this has been voluntary for hospitals. The  
21 place where I work, Providence has submitted over the years,  
22 but we have announced that as of the end of '12, that would be  
23 our last year of voluntarily reporting and so I would  
24 encourage a mandatory reporting that all are in and of course,  
25 then the big debate is what's the all? Does it include

1 military? Does it include the Tribal system?

2 I would argue it should and I know that there may be some  
3 issues with the Native system about whether or not the state  
4 could force them, but I would think it should be a condition,  
5 if you receive Medicaid dollars, you should have to report. I  
6 would think that would be a logical thing that should be  
7 linked together.

8 We shouldn't -- another principle, I would say, is it  
9 should not duplicate. I'd like to compliment the state on  
10 their proposed rule that was out for comment and closed on  
11 June 7th, and the state's going to start collecting some  
12 hospital acquired infection data and if it becomes a rule this  
13 fall and the state is doing this in a couple of ways that I  
14 think are principles that the Health Care Commission could do  
15 that is a good model to think about.

16 One is it's -- in the proposed rule, it's establishing an  
17 advisory committee to advise the state about what's this data  
18 mean. How do you communicate, and they're going to use in  
19 this case, the infection control expertise network across the  
20 hospitals in the state and it doesn't create new  
21 administrative overhead because it's going to be the data that  
22 we already are required to send to CDC and the state will  
23 then, by regulation, the hospitals will have to allow the  
24 state access to that. So it's no new administrative burden  
25 and yet, the state will have information, a certain amount of

1 hospital acquired infection data by hospitals.

2 Now, I would have been happier if the proposed rule  
3 included ambulatory surgery centers, because I think that's  
4 another place where things happen to people in terms of  
5 procedures, but at least -- and the CDC is going to start, or  
6 at least they're proposing in 2014 to start collecting some of  
7 this information from ASCs and so that -- and so it may make  
8 complete sense for the state just to follow in the lead of the  
9 feds.

10 We already report a lot of stuff to Hospital Compare. So  
11 if you think about quality data, which was referenced in the  
12 previous discussion before lunch, I would really urge that we  
13 don't have a new big administrative burden on providers, which  
14 I think is why doctors aren't in the current kind of  
15 discussion mix, because a lot of doctors are in small  
16 practices. We, hospitals, have a little more depth and  
17 breadth, but again, I think that it's important not to create  
18 a lot of new burden.

19 Then we should be really clear about why we're collecting  
20 data. It shouldn't be collected just to, because (sic). It  
21 should be for a purpose and finally, the final comment I'd  
22 like to make is that there needs to be some kind of a  
23 governance advisory committee, because there's a big risk when  
24 there's data collected that if it's released without thinking  
25 about it, one, it may not be understandable or two, with the

1 number of small towns we have in this state, that people's  
2 privacy might get compromised if you start having demographic  
3 information and disease diagnosis burden.

4 The State Department Division of Epidemiology does a  
5 really good job, I think when it releases data, thinking about  
6 that question, but that's a really important principle and if  
7 we collect a lot more data, we might really mess up unless  
8 we're careful.

9 MR. LEE: All right, thank you. I'm John Lee. I'm the  
10 CEO at Mat-Su Regional Medical Center and I want to thank you  
11 all for inviting me here. I appreciate the opportunity to  
12 come and speak to you. Just a couple of things, at the start  
13 of the -- first of all, Dick and I are fierce competitors at a  
14 lot of things and so -- but we're in complete agreement on  
15 this issue.

16 We've got a couple things in common. Actually, at the  
17 start of this today, we were talking about -- I was reading an  
18 article, the average length of time in the state of Alaska for  
19 a hospital CEO is 3.2 years and I think the American Hospital  
20 Association did a survey and we have one of the highest  
21 turnover rates and I'm at 3.4 years and Dick's at 3.9 years.  
22 So statistically, we're above average.

23 All right, but I don't want to repeat exactly what Dick  
24 said, because you know, we are in complete agreement on this,  
25 but I do want to point out -- to add to his comments. Health

1 care is fundamentally changed over the course of the last  
2 decade.

3 More and more health care is done on an outpatient basis  
4 and when hospitals across the country and states across the  
5 country began requiring hospitals to report data, hospitals  
6 were doing almost all of the health care, at least the types  
7 of data that's being collected, hospitals were doing that.  
8 That's not the case anymore.

9 Surgery centers, imaging centers, right now, a lot of the  
10 health care that's being provided in this state is being done  
11 in those facilities and if the state's not collecting data  
12 from these individuals or these providers, the state's missing  
13 out on the data and I do completely agree with Dick.

14 I think this data is very, very useful. It's very, very  
15 valuable for a lot of reasons and I think the state would need  
16 to have access to data from a variety of providers in the  
17 state if it's going to effectively do health planning,  
18 particular in regards to the CON, health policy issues,  
19 understanding where people are accessing health care and what  
20 health care is being provided. I think this data is very  
21 valuable and casting a wide net to collect that data, it would  
22 be very, very useful.

23 So when we stopped being members of ASHNHA over four  
24 years ago, we stopped reporting to ASHNHA and for a lot of  
25 reasons. You know, this is very -- as I said, it's very

1 important data. It's also very competitive data and in the  
2 state of Alaska, I think there's only -- about half the  
3 hospitals in the state report to the database.

4 There's about 13 hospitals that don't report and if only  
5 some of the hospitals are reporting, the hospitals that are  
6 reporting are giving up information that other hospitals are  
7 not giving up and if we're not members of ASHNHA, you know, we  
8 didn't have the ability to -- because in order to be able to  
9 get the data, you had to be a member of ASHNHA, and since we  
10 weren't members of ASHNHA, it just didn't make sense for us to  
11 continue to report.

12 However, I think -- and I'd be perfectly happy to provide  
13 that data, but I would like to see the state be the repository  
14 of this data and like Dick was saying, have all providers,  
15 hospitals for sure, provide this data, and you know, when Dick  
16 and I were talking about this, you know, and one of the things  
17 that I've seen at other states is in exchange for receiving  
18 Medicaid dollars, in exchange for the privilege, the  
19 requirement to report to the state on what services you were  
20 providing in exchange for that money and so like surgery  
21 centers, imaging centers, hospitals, and I don't want to, you  
22 know, set exactly what the list of providers should be, but I  
23 think, you know, that's certainly a subject of a good debate,  
24 but certainly those high volume providers who receive Medicaid  
25 dollars, to include the Native hospitals and I know, that you

1 know, military hospitals also can bill third-party insurances,  
2 but if you receive state dollars, I think in exchange for that  
3 comes an obligation to report the data.

4 So I think, as Dick and I both said, I think we'd be very  
5 happy to provide that data. I think the data's very useful.  
6 It's of, I think, a great value to the state and I think it's  
7 important, though, that if you're going to require data to be  
8 reported that you make sure that you cast a wide net and  
9 collect the data from all the providers that would be useful  
10 for the intended purpose, and thank you.

11 CHAIR HURLBURT: Thank you very much, both Dick and John.  
12 Jim.

13 COMMISSIONER PUCKETT: Yeah (affirmative), you both  
14 stated if a provider accepts Medicaid dollars and part of that  
15 is the state money, but would you extend that also to all  
16 state employees whose health care is covered by state dollars?

17 MR. MANDSAGER: I think the answer would be yes. It  
18 makes logical sense to me. I think that if that is a  
19 principle, then the other question is; where do you stop? It  
20 doesn't seem reasonable that we add an administrative burden  
21 to small doctor offices and stuff, and you know, I would view  
22 this as an incremental thing that you start with the bigger  
23 providers and at least the providers that cost the state a lot  
24 of money, imaging providers, us, hospitals, where procedures  
25 are done. I would probably start with that kind of stuff.

1           COMMISSIONER PUCKETT:  And that leads me to my next  
2 question.  I assumed you would say yes on that principle.  Do  
3 you have an idea where we would draw the line?  Would you make  
4 it a certain number of dollars per year or a certain number of  
5 patients?  Do you have an idea of where you'd draw that line?

6           MR. LEE:  I think you could take a look at, you know,  
7 where the dollars are being spent and draw the line.  I do  
8 want to state that it's -- for hospitals like Providence and  
9 Mat-Su Regional, and most hospitals in the state, you know,  
10 have pretty sophisticated information systems and for us to  
11 provide this data is simply creating an ad hoc query that  
12 pulls this data and reports it.

13           So when you get down to small individual physician  
14 offices, that's a huge burden and I think you would certainly  
15 want to do this fairly and include providers who are basically  
16 consuming a lot of the dollars and so with that larger  
17 expenditure would come a more sophisticated data system.

18           MR. MANDSAGER:  I'd like to add one more thing just out  
19 of our Providence experience working with critical access  
20 hospitals is that we -- it has been difficult for at least one  
21 of our hospitals to get it together every year to get the data  
22 submitted because they have -- their small administrative  
23 staff is doing a lot.

24           Now with our new EMR system, we're going to do it all  
25 centrally and we have the capacity to do it pretty much all

1 here in Anchorage and so Valdez, for example, won't get  
2 burdened by this. So the size of the hospital has to be  
3 thought about. The small independent hospitals, say in  
4 Kotzebue, new administrative burdens are real burdens and we  
5 should think about that.

6 CHAIR HURLBURT: You both heard the last presentation or  
7 at least part of it. I didn't see what -- when you came in,  
8 Dick, but in looking at the data sources and we've had the  
9 contract on the all-payer claims database with a group out of  
10 Boston that provided us information, to me, disappointingly,  
11 it just seems though consumers in the dozen states where it's  
12 been implemented have not really been utilizing it.

13 I was talking about it with Nirav Shah, who's the  
14 Secretary of Health in New York state, a couple of weeks ago  
15 and he was very enthusiastic. They have Medicaid with over  
16 five million enrollees there in the state, but I noticed it  
17 was classified as under construction, so he may have been  
18 optimistically enthusiastic, hoping you could get more out of  
19 it and you may not, either of you, have had any direct  
20 experience with seeing products of all-payer claims databases,  
21 but the intent on that is to (indiscernible - voice lowered)  
22 health care in terms of cost and in terms of quality, but if  
23 we, as a state, are going to go ahead and try to make the data  
24 that we get more robust so that Dick was saying it turns it  
25 into information, useable information, do either of you have

1 any sense, and maybe even a versus situation, of hospital  
2 discharge data versus all-payer claims database, recognizing  
3 that they're different products, but we probably as a state  
4 can't do all things at once?

5 MR. LEE: I think the -- hospitals and states have been  
6 collecting discharge data for a long time and so starting that  
7 up, I think, was a simpler project and then asking, I think,  
8 asking hospitals what they think about third-party payers,  
9 such as Blue Cross, Aetna reporting data to the state is kind  
10 of like asking the auto dealer or the Ford dealership what  
11 they think about the state requiring the banks what, you know,  
12 to report what the loans are for the -- for buying the cars,  
13 but really, since that's not my data, the -- you know, how  
14 difficult it would be for Blue Cross's and Aetnas to report  
15 this data to the state, I think they're certainly  
16 sophisticated and they could do that and I think for -- as a  
17 consumer, I think it would be very valuable to know what the  
18 cost of care is, what your co-pay would be at various  
19 treatment options.

20 So certainly, that's very valuable information, but you  
21 know, Dick and I don't control that data and I don't know if  
22 we could comment on how easy it is or what burden that would  
23 be for those payers to provide that information.

24 MR. MANDSAGER: I'll just add a comment or two. If the  
25 state goes down the road of an all claims payer (sic)

1 database, there needs to be some way to make sure there's a  
2 capture of self-pay, charity, insurance payments. So it gets  
3 bigger and more complicated really quickly if the intent is to  
4 really understand what the payment system -- and to have some  
5 understanding about cost shifting, if that's the intent.

6 I'm like -- I agree with John, we've been collecting  
7 discharge data, data that we know and we can control, or at  
8 least we have a pretty good sense about validity and so on and  
9 as we all know, we all negotiate with the payers for discounts  
10 and so on and we have viewed it as fairly proprietary  
11 information.

12 Once we go to an all payer claims database, it really  
13 changes the fundamentals and I really can't predict how it's  
14 going to shake out in terms of our relationships with Blue  
15 Cross and Aetna. I'd be interested in that in the other  
16 states that have done that, what's it done on the provider  
17 side. It clearly puts information about payments out there.  
18 It really doesn't say what the cost is.

19 It does show price versus payment and I think CMS did a  
20 really good job recently of at least putting that out there  
21 and so I'm kind of expecting, we're, as a country, going to  
22 make more and more of that available, but how useful it's  
23 going to be over time, I think is really an open question.

24 CHAIR HURLBURT: Yes.

25 COMMISSIONER HIPPLER: You just asked how -- or you

1 stated that there is the question of how useful it would be  
2 and you had previously mentioned that we shouldn't just  
3 collect data for the sake of collecting data. We have to have  
4 an end game in mind.

5 What -- so what would you like to -- let me back up. If  
6 we are collecting data, what kind of -- could you come up with  
7 one example of something that would be really helpful to  
8 either hospitals or insurance companies or actual consumers,  
9 one set of data that would be helpful to be disseminated?

10 MR. MANDSAGER: So John already said we're fierce  
11 competitors. I guess I'll throw out our story between the two  
12 of us here over the last six months. Providence proposed to  
13 develop a joint venture ambulatory surgery center out in the  
14 Valley. Why did we do it? We were curious and wanted -- we  
15 thought there was a chance that there was a need for more  
16 surgery rooms in the Valley. So we made our proposal.

17 There was no information available from the Valley, so we  
18 had no way of assessing was our assumption correct or not.  
19 Through the proposal process, the state decided there was not  
20 a need for more surgery rooms and denied the request. I think  
21 that's a tangible example of where data can be useful in  
22 trying to prevent overbuilding.

23 MR. LEE: And I think you asked what data would be useful  
24 and as Dick said, Hospital Compare, if you walk into our  
25 hospital, you'll see a big bulletin board that has the

1 Hospital Compare and not only how we score, but how we score  
2 compared to the other hospitals in the states and both  
3 Hospital Compare data, HCAHPS data, which is the patient  
4 satisfaction, so there are data sources that are out there  
5 that are useful that I think you could encourage consumers to  
6 get access to.

7 Frankly, a lot of people don't either know about it or  
8 take the time to do that. A lot of their health care  
9 decisions are based on what their friends are recommending or  
10 what their provider's recommending, but you know, there is  
11 very useful data out there and Hospital Compare is one of  
12 those data sources that's already out there that like Dick  
13 does, our hospital also reports to that.

14 CHAIR HURLBURT: So if an all-payer claims database,  
15 Dick, doesn't have the information related to uncompensated  
16 care, in terms of having more -- a more open negotiating  
17 process related to price, where prices are very high in the  
18 United States, very high in Alaska, and in terms of having more  
19 enlightened buyers in terms of quality outcomes, so you can  
20 measure that, is really the argument for the need to get the  
21 information about uncompensated care out there basically an  
22 argument you need to understand some of the constraints that  
23 we, as a hospital, are under and we are mandated to do this as  
24 a part of our -- the public charter that we were given to have  
25 a hospital, but does that really make a difference in the

1 other area, in having a more open negotiating process in terms  
2 of price and in terms of having a more enlightened process in  
3 terms of quality information?

4 MR. LEE: If I could, like Providence, we also provide  
5 charity care and uncompensated care and I think like  
6 Providence, we -- there was some discussion earlier about, you  
7 know, the industry standards providing at least 2% of your --  
8 compared to gross in charity care and I think it's safe to say  
9 that both Providence and my hospital provide well above that  
10 and it's a cost shift.

11 That cost has got to be borne through charging a little  
12 bit higher rates through third-party payers and so without  
13 that data somehow being in the mix, it will -- it certainly  
14 will -- it certainly paints an incorrect picture of what type  
15 of care is going on in the facility.

16 MR. MANDSAGER: I guess I'm -- I -- that's part of it, I  
17 guess, and I also think about kind of the balance of power and  
18 the conflict negotiation between hospitals and insurance  
19 companies and the public to your point where it's really  
20 important, I think, that consumers, when they're -- and small  
21 businesses, when they're buying, that they have some sense  
22 about are they getting a fair price, even if it costs way too  
23 much and I don't think anybody in this room would say that we  
24 think that we should -- can or should continue on the cost  
25 curve we're on as a country.

1           On the other hand, we've got to make sure we're a  
2 sustainable hospital for the next couple of generations.  
3 We've got to make sure that -- we owe it to the people here in  
4 Alaska that our institutions are here and so we have to make  
5 at least a margin that we can borrow money and so on when we  
6 need to make investments.

7           Now, we can have a big public debate about how much that  
8 should be. That's a fair debate, I think, but if insurance  
9 companies have all this information so they know what is being  
10 paid through their competitors, I've tried to figure out and I  
11 can't really figure out the new world, how we will negotiate,  
12 say with Jeff, with Premera, for example, when he knows  
13 exactly how much is being paid through Aetna and Signa and  
14 United and so on and it's going to clearly change our  
15 relationship in a way that I can't predict today how that's  
16 going to work out.

17           CHAIR HURLBURT: So the negotiation process is successful  
18 when you get to a win/win and to get there, it's probably most  
19 successful when each of the negotiating partners knows as much  
20 as they can about the person sitting on the other side of the  
21 table and what their constraints are and what the  
22 opportunities are.

23           So it's -- in a sense, is that the validity for making  
24 the argument, Jeff, you need to understand what we're  
25 providing in terms of uncompensated care and that needs to be

1 a part of your knowledge base in understanding what your  
2 negotiating partner across the table has? Is that maybe the  
3 driver for why it's important to have that information out  
4 there related to negotiation?

5 MR. LEE: You know, I would certainly love to know, you  
6 know, the discounts that Dick's hospital provides to each  
7 payer, and you know, so this is very, very competitive data  
8 and at the end of the day, though, it's -- I'm not sure if  
9 it's win/win. It's -- you're sort of mitigating your losses.

10 I think the insurance carriers don't really have the  
11 ability to absolutely steer volume. I think they can  
12 influence it, but the third-party payers don't necessarily  
13 have absolute control, exactly where that patient's getting  
14 health care, but I think, you know, there's a certain amount  
15 of steerage by the third-party payers based on the discounts  
16 and savvy consumers can certainly get a better deal going  
17 where their co-pays and deductibles -- where their co-pays are  
18 going to be less and their charges will be -- you know, what  
19 they're going to pay is going to be less based on the  
20 discounts, but at the end of the day, we haven't seen huge  
21 steerage of volume when you sign a contract, unlike what you  
22 would assume to happen. It doesn't always result in immediate  
23 steerage of volume when you sign these contracts.

24 MR. MANDSAGER: Yeah (affirmative), I think steerage of  
25 payers, I would echo what John said. I think up until

1 recently, there wasn't a great deal of steerage. It's more  
2 today than it was three years ago and I expect as the  
3 deductibles and co-pays to increase, steerage will -- power  
4 will increase with the insurers, but historically in Alaska,  
5 it's been pretty small. It's changing fairly quickly, I  
6 think.

7 MR. LEE: I think Dick hit on something. I think one of  
8 the big drivers of consumer choice right now is with the  
9 rising cost of health premiums, employers can't afford to  
10 provide the, you know, the insurance that they used to be able  
11 to provide.

12 So a greater share of the burden's going to the employee  
13 and so you have higher co-pays and deductibles and it's not  
14 unusual to see five or even in some cases 10,000-dollar  
15 deductibles and that creates a lot of shopping behaviors for  
16 the elective procedures and where they get their care.

17 CHAIR HURLBURT: Keith, yeah (affirmative).

18 COMMISSIONER CAMPBELL: I've been pondering this whole  
19 thing for a while and I cannot see the ultimate benefit to the  
20 patient yet, at least of the data sets and stuff that we've  
21 been researching around the country.

22 Yeah (affirmative), theoretically, you can -- you know,  
23 this appendectomy cost me here, here, you know, all around,  
24 but it's not happening. With all this data that's being  
25 collected, I didn't see in any of these studies where it had

1 any, in my view, any practical application for the individual  
2 patient.

3 It might for a clinic who could steer somebody some  
4 place, but even with the outcomes data, this sort of thing,  
5 it's just a nebulous thing in my mind and the investments are  
6 huge here, folks.

7 The money -- the maintenance cost alone are huge and I'm  
8 sitting here trying to represent the consumer and pondering  
9 whether this is just a nice exercise in -- or not or is it  
10 going to have an ultimate practical value for the patient?  
11 Somebody tell me.

12 CHAIR HURLBURT: Were you talking about the all-payer  
13 claims database specifically, not the discharge database?

14 UNIDENTIFIED SPEAKER: So can I.....

15 MR. CAMPBELL: They're basically integral in a lot of  
16 ways.

17 MR. MANDSAGER: So here's one example of it and I think  
18 something -- if -- in my own head, that at least the data that  
19 John and I came to talk about I think has value, potentially  
20 in two areas, certificate of need decisions and some  
21 population (indiscernible - voice lowered).

22 I was talking to one of the state employees that is  
23 making geographic information available and has been  
24 struggling with how to show communities the cost of diabetes  
25 in their community.

1           Unless you have a fairly complete list of procedures or a  
2 listing of procedures by Zip code, it's very hard to really  
3 show back to the community what the burden of -- secondary  
4 burden of disease is. I think it's very hard to show a direct  
5 one on one to a patient corollary, but I think to a community,  
6 you can construct some limited data set that probably has  
7 value, if maintained over time, but you've got to be in it for  
8 the long haul.

9           CHAIR HURLBURT: David.

10          COMMISSIONER MORGAN: I've -- since I'm a professional  
11 joiner-upper, the healthcare -- the group in the state, the  
12 Healthcare Insurance Underwriters Association, I've gone to a  
13 couple of their statewide meetings and they currently have  
14 sort of developed their own, basically using information with  
15 their administrators for their underwriting and they're the  
16 only organized group that I -- which I was fascinated by this  
17 and looking at it, but they are the ones -- are basically the  
18 largest group.

19          It's not a huge number of patients, but on about 12 or 13  
20 diagnostic groups, and they're mainly elective type stuff, are  
21 using that type -- this type of data and sending people or  
22 basically doing travel, exporting out of the state to -- using  
23 their data and then getting quotes for certain procedures.

24          It's small, but they were telling me that it's, in the  
25 last three years, it's doubled for each year. I think it

1 might be interesting to have those guys come in and show us  
2 for a half an hour, an hour, just what they're doing and how  
3 it has been -- that data has been used.

4 Now, they use their data sets that they've developed  
5 themselves over the last 15 years of -- they're paying, so  
6 they've sort of made their own database to make the  
7 comparisons and then, basically, their claims processing  
8 people make phone calls, like if somebody's going to get a  
9 knee replacement or something, they call the four or five  
10 specialty groups or hospital or whatever to do that and then  
11 they have relationships with Seattle and Portland and other  
12 places and that's how they've utilized the data.

13 Now, probably you guys are -- you're right, Keith, that  
14 probably it's not a customary thing to do here by the normal  
15 consumer, but I think in some markets, especially in Portland  
16 and some other areas, I know in North Carolina, they do a lot  
17 of this stuff with their database.

18 So I just think it would be interesting to hear from  
19 those guys of what they got and how they use it, which would  
20 be a mini version of this.

21 CHAIR HURLBURT: Do you have any.....

22 MR. MORGAN: If nothing else, they could tell good jokes,  
23 if nothing else.

24 CHAIR HURLBURT: Do you have any sense, David, of how  
25 many enrollees they're having -- generating their database

1 from?

2 MR. MORGAN: I just remember them talking about -- I was  
3 there giving a little talk on affordability care and its  
4 impact. This was a year-and-a-half ago. I just can't  
5 remember. It wasn't huge, but it wasn't teeny either. It was  
6 basically all of those and plan administrators pooling their  
7 data to make these decisions. I just think it might be a  
8 little interesting to hear what they said. I've actually sent  
9 an email and invited their President to come today, but I  
10 don't think they're here.

11 CHAIR HURLBURT: Bob, did you have a comment or you were  
12 just scratching your nose or something?

13 COMMISSIONER URATA: I'm thinking of a comment.

14 CHAIR HURLBURT: Okay, Jim has one and then we'll come  
15 back to you.

16 COMMISSIONER PUCKETT: No, I just wanted to volunteer in  
17 response to (indiscernible - voice lowered) Mr. Campbell's --  
18 so far, I'm looking at the database and the perspective, in  
19 order for our citizens to be better consumers of health care,  
20 they need information and so that's what I'm looking at.

21 Is the information that would be found in the database,  
22 would that be of the sort that people could look at to make  
23 more informed decisions? Now, that question is still open.  
24 We don't know that and again, would they even use it, and so  
25 that's the basis of what I'm examining is the database would

1 have the information available that would help people make  
2 better decisions. They need to be better consumers of health  
3 care and then again, would it be in a form that they would  
4 utilize it.

5 Some other states have shown that the people have not  
6 utilized it like they expected them to, so -- but that's what  
7 I'm looking at is -- will it help them mitigate some of their  
8 own health care? I don't know, but the idea is that in order  
9 to be a good consumer, you've got to have information and if I  
10 want to buy a car, I can go out and do the research pretty  
11 easily, but if I want to get -- I want to make a decision on  
12 something's that going to be done to medically, it's very,  
13 very difficult for me to get that information.

14 COMMISSIONER CAMPBELL: That leads me to the question --  
15 the state had a PTO type arrangement with, who is it now this  
16 year, you're trying to -- is it between Providence and Humana  
17 or didn't I read something that you had some sort of a little  
18 kind of a preferred discount in one of these institutions?

19 COMMISSIONER PUCKETT: A preferred hospital in  
20 (indiscernible - too far from microphone), yes.

21 COMMISSIONER CAMPBELL: Is that driving volume in your  
22 mind?

23 COMMISSIONER PUCKETT: Is it driving volume  
24 (indiscernible - too far from microphone)?

25 COMMISSIONER CAMPBELL: To one or the other, to your

1 institution of the year, whoever has the contract, is it  
2 driving volume to that institution versus the normal  
3 prescribing pattern? If you have a physician and he's got  
4 privileges at Prov or Humana or the Valley, would they --  
5 would this encouragement in the state contract for the  
6 employees, would that drive that volume, for instance, if the  
7 Valley won it for a period of time? Would they actually get  
8 those patients to travel out to that or versus Providence  
9 versus Humana? Do you get any volume shift by having that  
10 contract with them?

11 COMMISSIONER PUCKETT: We have experienced a shift in the  
12 volume, but what I'm looking at is for the individual members  
13 to make their decisions outside of a network. As I've shared  
14 in the last Commission meeting, a plan of our size, we're  
15 going to examine the data anyway.

16 We've got our own claims data. So we're going to do our  
17 own research and data analytics, but outside of that, the  
18 people in the state deserve to have information. What form  
19 that's going to be in, we don't know yet, but yes, we have  
20 seen a change in the volume.

21 COMMISSIONER HARRELL: So I've had sort of an evolution  
22 of thought as we've discussed this over the last couple of  
23 months and initially, I was very much in support of it, but  
24 I've begun to question my initial positions, specifically  
25 because of the comment that Keith made.

1           It seems the more we see about the all-payer claims  
2 database and the behavior that it can drive, that behavior,  
3 that consumerism is episodic in nature and that's how we use  
4 cost data as consumers to go buy a car or to decide whether  
5 we're going to go to Costco or to Walmart based on what the  
6 sales price is of a particular item that we're looking for,  
7 but as a cardiologist, the kind of impact we're looking for  
8 here, though, is chronic care related.

9           These are disease states that occur over time and so I  
10 wonder if we're not going to get to the pot at the end of the  
11 rainbow with this, because the kind of behavior that we're  
12 more likely to drive in the near-term are going to be the prev  
13 med related type episodes where, "Hey, I want a colonoscopy.  
14 There's nothing wrong with me, but I know I need to get this.  
15 So where's my best price?"

16           That doesn't require an established relationship, but the  
17 disease states we've talked about that are going to be  
18 impacted by better health care are chronic disease states that  
19 require an established relationship with a provider to be able  
20 to achieve (indiscernible - voice lowered). So I'm curious as  
21 to what the rest of the group thinks about that.

22           COMMISSIONER URATA: Well, and I would kind of agree with  
23 you. I think if Mr. Miller had said in one of his slides,  
24 that you know, an area that they're heading toward is looking  
25 at, you know, the number of diabetics and a lot of that care

1 is done in offices and we're not going to be collecting data  
2 from the offices, but maybe we should, but it would be  
3 difficult, I think, for small offices to collect that data,  
4 unless you had a robust electronic medical records system.

5 The hospitals, though, I guess cost the state a  
6 significant chunk of money and with the all-payers claim,  
7 maybe they could reduce some of that and put more of that  
8 money back into the, you know, the offices or just, you know,  
9 just save the money.

10 So I agree, you know, I'm not so sure that this would  
11 benefit the consumers. Though it might benefit the consumers  
12 indirectly by looking at some of the data for, you know, the  
13 public health or population health systems that I think we're  
14 kind of heading towards, but I agree with you. I'm kind of  
15 mixed right now. It's been -- at first, I was really -- I  
16 really thought this was a no-brainer.

17 CHAIR HURLBURT: Dick, yeah (affirmative).

18 MR. MANDSAGER: The -- it may be, too, that five years  
19 from now, it has fundamentally changed, as EMRs finally start  
20 becoming more linked in a way that data flows more easily and  
21 so on, because too, what Dr. Urata said, "If we're going to  
22 really capture the cost of chronic disease, you've got to get  
23 information from the offices," and so on and I do think that  
24 there's an accelerating journey now that EMRs may actually  
25 start talking with each other.

1           If that happens, then some of this may become cheaper to  
2 collect it. The administrative burden may come down in a way  
3 -- and the metadata analytics tools will also get stronger,  
4 too.

5           CHAIR HURLBURT: David.

6           COMMISSIONER MORGAN: Jeff had a comment.

7           CHAIR HURLBURT: Jeff.

8           COMMISSIONER DAVIS: So I think our discussion's getting  
9 a little confused, because we're talking about two things at  
10 the same time without identifying what -- the thing we are  
11 talking about. So in my mind -- okay, I'll (indiscernible -  
12 voice lowered) an all-payer claims database is one thing and  
13 what has just been described is not a discharge database, but  
14 an expansion of a service database, if you will, and although  
15 there are some similarities, there seem to be differences.

16           So one of the things that troubles -- so I'll talk about  
17 APCD first and one of the things that I think is difficult  
18 with APCD is, and we've discussed this with the consultant,  
19 and it was that the breadth of the data that you capture. The  
20 state has the authority to regulate the business of insurance.  
21 The number of people who have an insurance card, or actually,  
22 an insured product in Alaska is very small. It's maybe  
23 150,000 people that could be compelled to deliver their data.

24           Okay, the self-insured are not regulated by the state.  
25 So even though we might administer them, over half of our

1 business is self-insured, we cannot be compelled to deliver  
2 that data and maybe we would, maybe we wouldn't, but every  
3 self-funded employer would have that same decision point.

4 So now Medicaid probably could be convinced, but not  
5 Medicare and not IHS and not DOD. So what do you have? You  
6 don't have an all-payer claims database. You have an all-  
7 insured clients database. So that seems very limited and in  
8 terms of applying it to a population.

9 The second thing is that -- to my question to Mr. Miller  
10 was, give us some examples of where things have changed in the  
11 real world because of the use of this data, the millions and  
12 millions of dollars that have been spent and opportunity costs  
13 of the labor and the only examples that I recall him giving  
14 were more about population health and a hope that somehow --  
15 that at some point it would be used for payment reform.

16 Okay, so then the other part of that or of this, is that  
17 there is, as has been described here between Mat-Su and  
18 Providence, there's a competitive environment that we're  
19 entering into. We seek, with the use of our data and an army  
20 of actuaries, to create competitive advantage and we seek to  
21 help our employer clients identify where there is opportunity  
22 for them to intervene on work site wellness type activities  
23 and we seek -- use our data to determine where we have  
24 opportunities with providers.

25 So that's a bit of advantage to us and would be to

1 others. So if we give up a whole -- we give up that to gain  
2 something that I think is -- has a limited utility, as I said  
3 in the beginning, so then thinking about what you've  
4 described, if it really is an all service database and you  
5 draw the line at a place where it's meaningful, somewhere  
6 above the provider's office, but including, probably the list  
7 that, Dick, that you've described, then you capture a much  
8 larger share of what's actually being done and if you were to  
9 limit it, at least initially, to those things that you  
10 describe that already need to be reported that could have some  
11 utility, then perhaps we could build something with a lot less  
12 effort that was much more meaningful and probably it's meaning  
13 is in the area of population health, which is what the all-  
14 payer claims database seems to deliver as well.

15 So if I look at those two things and compare them and  
16 contrast them, it seems like we're a lot closer to having  
17 meaningful, credible, actionable data if we use -- do the  
18 service, all-services database than we would from an all-payer  
19 claims database, because it's not all payers. Thank you.

20 MS. ERICKSON: I actually -- Jeff, just wanted to clarify  
21 that there -- the existing all-payer claims databases are  
22 capturing third-party administered claims. Eight of the 10  
23 existing ones currently are. There are the three new ones  
24 that are just about to come online and I read the state laws  
25 that created those and all three of those compel third-party

1 administrators, whether they're licensed or not, to submit  
2 claims for the residents of their states.

3 So we would capture that and Medicare is participating in  
4 the all-payer claims database. So there would be more, not to  
5 counter your point, but just wanted to clarify that.

6 CHAIR HURLBURT: But the state legislation, apparently,  
7 is successfully able to compel the ERISA protected payers to  
8 have to submit that data. David, yeah (affirmative).

9 COMMISSIONER MORGAN: If you -- in the legislation, if  
10 you're getting Medicaid, receiving payments for Medicaid, I  
11 don't know of any Tribal group, facility, activity that  
12 doesn't bill Medicaid. They can. That's legal to do it. So  
13 if you follow the Medicaid concept, then, in the legislation,  
14 then that would pick up your Tribal entities and I think some  
15 of them did it that way, if I remember between all of these  
16 pills I'm taking for the last three days.

17 So I mean, if you're wanting to make a big net, you can  
18 add -- there's a part of it and it sounds like Medicare's  
19 helping or has agreed. So it's not as narrow as -- the real  
20 question is; is there utility? Can it be explained and if we  
21 do it, will they come? Almost -- I think -- and that's the  
22 issue that we all have to think about and do.

23 I'm assuming that we'll eventually talk to a few of the  
24 states that are doing it or you have already, haven't you,  
25 Deb, called them? What -- I hate to -- I'm not calling you as

1 a witness, but what do they say about this, I mean.....

2 MS. ERICKSON: I'd need to (indiscernible - too far from  
3 microphone).....

4 COMMISSIONER MORGAN: Well, the utility -- the utility  
5 issue.

6 MS. ERICKSON: No, I need -- I would need to ask them a  
7 more specific question.

8 COMMISSIONER MORGAN: Right.

9 MS. ERICKSON: If you want to bring a specific question  
10 to me to bring to the other states, I can do that.

11 COMMISSIONER MORGAN: Okay. Well, I meant -- is there  
12 utility? What Jeff said, is there utility and what Robert  
13 said, does this help? Does it provide information that's  
14 used? Is it kosher, I guess?

15 MS. ERICKSON: Yeah (affirmative), the folks who I talked  
16 to think that it does, believe that it does, but if we were to  
17 ask them a real specific question for proof on return on  
18 investment or direct examples, I probably could get at direct  
19 examples of how the data has been used beyond results  
20 experienced from some of these applications that we saw today.  
21 So we could have that follow-up question to them.

22 COMMISSIONER BRANCO: I'd like to describe a little bit  
23 of an ethical dilemma that we're facing right now based on one  
24 of our first presentations today, and I really want to thank  
25 John and Dick for their presentations and if we shift back to

1 the hospital discharge database, the utility of that has been  
2 lost on me over the years.

3 Quite frankly, when I provided data, I never looked at  
4 the reports because they were mildly interesting and if you  
5 use the car analogy that was used here, does it really matter  
6 to me if more people in Anchorage buy Fords than Chevy's? I  
7 don't really care.

8 It doesn't change who I am. Unless I'm driven by that  
9 market force that says, "Well, perhaps I should buy a Ford,  
10 too, because more people do and they must be smarter than I do  
11 (sic)." That's about the utility of the data that I've been  
12 given.

13 There is utility to others, but now I want to hit the  
14 moral dilemma piece and that's on whether the all-payer claims  
15 database or hospital discharge information, if we have a  
16 compulsive program to provide that data, there's an expense  
17 associated with producing that information, wherever that  
18 exists.

19 I'm not saying always, but sometimes those come in the  
20 form of an unfunded mandate. Take it out of hide to produce -  
21 - to put the people to work to produce that information on a  
22 recurring basis and the hours spent to do that, the cost is  
23 shifted somewhere and usually to the consumers. So there's a  
24 small moral dilemma. Do we add cost to a system to get some  
25 information back that actually costs more when our goal is to

1 reduce cost? So it's a small moral dilemma.

2 CHAIR HURLBURT: Dick, yeah (affirmative).

3 MR. MANDSAGER: Can I follow up on that topic, because I  
4 think it's actually not such a small moral dilemma and I'll  
5 just use our example here in Anchorage. So hospitals and ASCs  
6 are in competition, too. Hospitals have the obligation to  
7 stay open 24/7 and keep an ED. ASCs don't.

8 As surgical volume has left hospitals, that's been a  
9 place as we, Americans, like to reward you for doing things,  
10 so that's where a lot of the money is in the doing stuff.  
11 Money has left hospitals. We have more of an administrative  
12 burden reporting than the ASCs do that don't and I don't think  
13 that's fair over time. I think that if we're going to stay in  
14 the reporting business, it's got to be equalized.

15 CHAIR HURLBURT: John, yeah (affirmative).

16 MR. LEE: Yeah (affirmative), and I agree with Dick. You  
17 know, really, I look at this simply. I'm happy not to report  
18 the data, but if compelled to report the data, I'm very happy  
19 to do that as well, but if data's collected, I think it needs  
20 to be a wide source of data for it to be meaningful, and you  
21 know, a good way to look at it is every hospital that receives  
22 Medicaid dollars in the state would report and if you're the  
23 benefactor of a CON to operate, then potentially, that could  
24 be the other source of data that's required to be reported and  
25 whether or not it needs to go any deeper than that, down to

1 the provider level, you know, that's something that you all  
2 could decide, but simply, if you're benefitting from the CON  
3 or if you're receiving Medicaid dollars in your hospital, I  
4 think that potentially could be the threshold of what would be  
5 required to report.

6 Again, I'm happy not to report and if it's being  
7 reported, it needs to be a wide collection of data for it to  
8 be meaningful. Otherwise, it's just a process by which we're  
9 creating ad hocs and submitting it to somebody that it may or  
10 may not be meaningful to anybody.

11 CHAIR HURLBURT: One of the things we'll talk about later  
12 is going through the legislative audit process that's been  
13 recommended to Deb and me that we be more specific in regard  
14 to some of our recommendations and so one of the things that  
15 I'm hearing, I believe, and I'm asking you to correct me if  
16 I'm incorrect, from both Dick and John is that you are quite  
17 open to complying with a uniform mandate for the discharge  
18 data reporting as long as it is in the several kinds of  
19 formats that Dick described initially.

20 One, that it be user friendly, using the hospital  
21 acquired infection draft requirements now, preferably so that  
22 it's something you're already doing that doesn't impose a lot  
23 of added cost and two, that it be fair, that it also extends  
24 to other providers in a reasonable way, not to the sole-  
25 practitioner, but to the ambulatory surgery center, the

1 diagnostic imaging center and maybe some others, but that if  
2 the state were to propose legislation requiring that to get  
3 more information, and this is not addressing the issue that  
4 Pat raises, but if we were, you could live with that and that  
5 would be acceptable to you all, is that correct?

6 MR. MANDSAGER: In general, I think my personal answer  
7 would be yes. Obviously, the devil will be in the details.

8 CHAIR HURLBURT: Yeah (affirmative).

9 MR. MANDSAGER: And I'm not going to say we're not going  
10 to argue about it depending -- until we see legislation, but I  
11 suspect we would be supportive.

12 CHAIR HURLBURT: Then the second issue addressing the  
13 issue that Pat raised is the moral dilemma of what value is it  
14 and what we heard today was partly the value of getting the  
15 population data. What I heard your suggestion, Dick, was that  
16 let's wait a little while, that when you have a data system  
17 such as you and I had in the Indian Health Service system or  
18 such as your data system now, Epic, and that I had at Group  
19 Health in Seattle, that we've got a lot of that information  
20 and that if you just wait a little while, that this with  
21 (indiscernible - voice lowered) and at ANMC or Epic that you  
22 all are using, that within a few years, we will have that data  
23 in a system that we're getting for other reasons, including  
24 federal enticements to do that. Is that valid?

25 MR. MANDSAGER: (Indiscernible - too far from microphone)

1 cost. Yeah (affirmative), I think right now, it is so  
2 laborious, that there's a big administrative overhead on  
3 trying to manipulate data from a multiplicity of sources.

4 CHAIR HURLBURT: Anything else on this? Thank you, John  
5 and Dick, very much for coming. I think this was very helpful  
6 to us.

7 MR. MANDSAGER: Thank you for the opportunity.

8 CHAIR HURLBURT: Sure. We're just about at the time for  
9 the public comment period. Again, if anybody in the public  
10 group in the audience here would like to comment on something  
11 and you haven't signed up, please sign up at the back of the  
12 room there and I'll ask, is there anybody online who would  
13 like to make a public comment? We can't hear yet, okay?

14 UNIDENTIFIED VOICE: (Indiscernible - too far from  
15 microphone).

16 MS. ERICKSON: So if there's anybody online on the  
17 webinar interested in commenting, if you could go to your chat  
18 and let the organizer know. We'll put you on the list and  
19 then we can open up your line for you and Ward, we have four  
20 people on the list, but I'll give those to you here in just a  
21 second. We'll check the back of the room.

22 CHAIR HURLBURT: We have four people in the room who have  
23 signed up to give comments and we don't know yet about folks  
24 online, but we'll be checking. We're doing well on time and  
25 for the folks who have public comments, normally we would ask

1 that you limit it to a three to five-minute timeframe, but if  
2 we could start with Karen Purdue, and Karen, if you would like  
3 to take a little more time than that, I think we're in good  
4 shape and particularly related to hospital discharge database,  
5 since the ASHNHA has been involved with that and then, you've  
6 been very engaged and knowledgeable. We welcome what you have  
7 to say.

8 MS. PURDUE: I do have some material that I'll pass out.  
9 I hope I have enough copies for everyone and I'm not going to  
10 -- it's a three-page document, so I'm not going to read it,  
11 but for the record, my name is Karen Purdue. I am the CEO and  
12 President of the State Hospital Nursing Home Association and I  
13 did prepare some comments on the hospital discharge data  
14 system and on the all-payer claims database that I would like  
15 to share with you.

16 It is true that ASHNHA has been involved in  
17 administering, jointly administering with the state the  
18 discharge system since 2001, and I guess there's one thing I'd  
19 like to leave you with now, which is I think the system, the -  
20 - I do not want you to believe that the discharge system is  
21 broken. It is not broken. It is a good model of cooperation  
22 between an industry and the state government in collecting  
23 provider data. It is our best model, I would put forward.

24 Did ASHNHA do this because they initially wanted to? I  
25 think Dick and others would say and we would all say -- when I

1 was Commissioner, I think we began this dialog. The state  
2 wanted to regulate more directly, the collection of this  
3 information and so industry stepped forward and said, "We will  
4 do it in cooperation with you," and anything we do going  
5 forward in this area or in the discharge -- in the all-payer  
6 claims database, I think we need to take that as a model.

7 The -- we are -- we have been slowly working to improve  
8 the number of facilities who are using and reporting to the  
9 system. We now have, as of this year, 90% of the discharges  
10 for all non-federal facilities. Now, we do not have the one  
11 facility in Mat-Su.

12 One of the things that I think is not well understood is  
13 that ASHNHA does not see the detailed data of the facility.  
14 That is only reserved for the state and for the contractor who  
15 is the Missouri (indiscernible - voice lowered) organization.  
16 So ASHNHA does not review what might be considered proprietary  
17 information.

18 In addition, when the state produces information or when  
19 we, then, get our data back from the data repository, there  
20 are protocols for protection of that data between the  
21 facilities. So there has been some work that has gone into  
22 designing this system and I would say for the most -- I have  
23 never heard a complaint from a facility, but now, I probably  
24 will, but I've never heard a complaint that information has  
25 been breeched or in any way not used (sic).

1           Having said that, I think our relationships and the data  
2 sharing is more conservative than the new climate is and we  
3 could use a refresh of how that's done. I think that the data  
4 needs to be used more. I think, as Pat said, Pat is not the  
5 only facility who believes, that you know, the classic concept  
6 of reporting is if you get something back, you're more excited  
7 about reporting it and I think if we could show more work  
8 product from the data, then I think that we would have, also,  
9 a more robust system.

10           I think that goes to resources and if this Commission  
11 wants to support the discharge system, I think we really need  
12 to look at the resourcing of the discharge system. Now, does  
13 that mean it all has to be state money? Maybe there's a way  
14 hospitals can contribute some of that resource, but I think  
15 the state is under-resourced in the way that they are using  
16 this data.

17           Every year, for instance, the administrator of this --  
18 keeper of this flame has to go to each division and request  
19 money on an ad hoc basis to fund that activity. That's  
20 \$80,000 that this system runs.

21           Should this system be a mandate versus a voluntary? It  
22 has been a voluntary and it has been -- it has been, you know,  
23 working until we've -- until this current situation, where we  
24 have a very large system, Providence, saying they will not  
25 participate if not all facilities do participate.

1           So obviously, if we have to go to a mandate, we do, and  
2           in that case, we absolutely believe that relevant providers on  
3           the outpatient side should be reporting. So ambulatory  
4           surgery centers and others should be reporting.

5           You know, there's a whole good thing about being  
6           voluntary and working together and I wish we could keep that  
7           spirit alive as we look at moving to a mandatory system. I  
8           think it is an option for those facilities who do not want to  
9           report through the current system to report directly to the  
10          state. So that's another alternative for Mat-Su to think  
11          about.

12          We have contracted with NAHDO to -- we, ASHNHA, along  
13          with the office that administers the discharge system, to look  
14          at legislation or regulatory or legislative frameworks for  
15          governance and for data elements that would be in a discharge  
16          system and we expect to receive that work product in August.  
17          Governance could be strengthened. I think I already touched  
18          on that.

19          The other thing that we're very interested in is the work  
20          that this Commission has heard about around the IBIS system,  
21          which is the public health reporting system, and that system  
22          is, again, something on deck that's real. That's resource.  
23          That could come online here in the next couple of months. It  
24          will have population based health information in it, such as  
25          we've seen on these charts today and hospitals could provide

1 more detailed information to that system than they are  
2 currently planning.

3 It's being done now by region. So in some cases, like  
4 Pat's region, it probably doesn't matter, but in Anchorage, it  
5 might matter. So we might be able to do something more there  
6 with that system that's already on deck and that would be  
7 useful and we've looked at what Utah has done in that area.

8 Regarding the all-payer claims database, we are still  
9 trying to get our mind around it. ASHNHA, as a board, has  
10 discussed the all-payer claims database or been presented on  
11 it. I would say, I was trying to think today, maybe eight or  
12 nine times, and I would say that our members still do not  
13 really grasp the basic fundamental reasons that we would be  
14 doing it and that, I think, would be fundamental for us moving  
15 forward.

16 We have a lot of detailed questions that are not, you  
17 know, they're important, such as governance, what are the  
18 elements? Those kinds of things, but in general, as I've said  
19 before, it's a big, hairy idea. It takes all the information  
20 from one industry and it puts it in a bucket that is managed  
21 by government.

22 So you know, obviously, we know that has been done, but  
23 we also are a highly focused privacy state. So what are those  
24 protocols? What are those things that would be in place to  
25 protect breeches of the system, and let me just give you an

1 example in Alaska of how we might be different.

2 I noticed in the material that Mr. Miller gave, one of  
3 the last slides was about the electronic information exchange  
4 and all the items that it does provide, the last slide. We  
5 have just launched our go live. We will be launching our go  
6 live on our health information exchange in Alaska next week in  
7 Fairbanks, a nice cooperative project between Tanana Valley,  
8 Fairbanks Memorial and Chief Andrew Isaac.

9 We worked for five years to do our privacy and security  
10 policy and when we were ready to launch go live, the ACLU came  
11 forward and said, "Your privacy and security policies are not  
12 good enough," and so we had to make dramatic changes to our  
13 system. Our system will not -- we are not -- we are telling  
14 our patients who are using that system their health  
15 information is only going to be used for their personal health  
16 visits. It is not going to be used for a broad or public  
17 health advice, you know, analysis at this time. So we have to  
18 walk slowly toward these milestones of taking these large  
19 databases and using them for broad purposes.

20 So in conclusion, I think we at ASHNHA will continue to  
21 work on transparency. I think we will -- we'd like to work on  
22 the discharge system and strengthen it. We're interested in  
23 those other public health measures that the division has or  
24 the department has going that we could work on.

25 We would actively participate in a stakeholder process on

1 the claims payment system so that we can delve deeper and get  
2 some of our more detailed questions answered and would do what  
3 we could to go back to our membership. I'm sure everybody  
4 would be at different levels of comfort, but right now, we're  
5 not -- we don't have enough information to say that we believe  
6 that is the place to go and what we don't want to do is lose  
7 focus on the things that we already have in place that can be  
8 strengthened. Thank you.

9 CHAIR HURLBURT: Before you move, I'll go outside our  
10 normal process, because you have been very central to this  
11 right along -- does anybody have any questions for Karen  
12 before she goes back? Okay, thank you very much.

13 MS. PURDUE: I wanted to just make a note. I wanted to  
14 thank Pat Branco for his service on behalf of ASHNHA on this  
15 Commission. It has been a real labor of love that he's  
16 devoted coming from Ketchikan for these meetings and we, in  
17 the association, strongly and truly appreciate your efforts.

18 CHAIR HURLBURT: Thank you, Karen. Marge Stoneking.

19 MS. STONEKING: Hello, I'm Marge Stoneking. I'm the  
20 State Director for American Lung Association and so I'm here  
21 today to speak from the perspective of public health and how  
22 systems such as the mandatory hospital discharge data  
23 reporting and the all-payer claims database could make a  
24 difference in public health.

25 So for three reasons, and obviously, we're interested in

1 respiratory disease. Chronic respiratory disease can be  
2 affected by these data systems and specifically asthma. You  
3 saw some examples about asthma in Patrick's presentation  
4 earlier about the all-payer claims database.

5 So first, and this is something that Dr. Mandsager  
6 mentioned, this data could be used to demonstrate the  
7 secondary burden of a disease on a community, that is the cost  
8 burden. So asthma is a chronic disease that is a huge cost  
9 driver in health care and if asthma is managed, it's a huge  
10 opportunity for reduction in health care.

11 So being able to demonstrate that disease burden beyond  
12 the individual, beyond the health care outcomes, but to the  
13 economics of it is a big opportunity for health savings.

14 Secondly, to target or pinpoint the population or  
15 geographic areas for public health interventions beyond  
16 prevalence data -- so what we have right now is (indiscernible  
17 - voice lowered) data, which tells us lifetime or current  
18 prevalence of asthma and so if the prevalence of asthma goes  
19 down, does that mean we're doing well? Not necessarily,  
20 because it may mean that our doctors are not diagnosing it or  
21 that people are not going in to get service and treatment.

22 So with asthma, you need them to be going to their  
23 provider. It's chronic disease management and you need to be  
24 able to demonstrate where those interventions are happening at  
25 the individual level. So for instance, are they going to the

1 emergency room? Are they seeing a primary care provider? Are  
2 they seeing an allergist? Are they using controller  
3 medications? Are they using emergency medications, that kind  
4 of thing.

5 Then third, to evaluate a public health program, a  
6 database such as this would be useful on a chronic disease  
7 management kind of program like asthma. So currently, the  
8 American Lung Association is administrating the state asthma  
9 control program in lieu of the Department of Public Health and  
10 we have no way to go back to the Legislature and say, "We're  
11 making a difference," because again, prevalence data is not  
12 going to show the outcome of community interventions or policy  
13 changes on asthma.

14 CHAIR HURLBURT: Thank you very much. Anne Lovejoy.

15 MS. LOVEJOY: No, I have no comment.

16 CHAIR HURLBURT: Okay, and then the other one I have on  
17 the list was Dr. Ilona Farr, but I think she left this morning  
18 to go back to the office. So she may have signed when she  
19 first came in. Where do we stand with anybody on the phone?  
20 If we.....

21 MS. ERICKSON: Nobody's indicated an interest in  
22 testifying over the phone. So if there isn't anybody else in  
23 the room interested in testifying, we could -- could and  
24 should probably take a 10-minute break before our next  
25 session.

1 CHAIR HURLBURT: Okay, so hopefully, our technology will  
2 work with th next session. So we'll take about a 10-minute  
3 break and come back together.

4 1:43:56

5 (Off record)

6 (On record)

7 2:00:51

8 CHAIR HURLBURT: I think we've got the technology worked  
9 out now and we should be in good shape. Our next presenter is  
10 Dr. Suzanne Delbanco, who is the Executive Director for  
11 Catalyst for Payment Reform. This is an entity that is doing  
12 a number of very interesting papers and analyses related to  
13 some of the payment kinds of issue.

14 Their seal says, "Our healthcare system needs CPR," or  
15 the Catalyst for Payment Reform, but I think we would all  
16 agree that it does. We appreciate Dr. Delbanco being  
17 available to talk with us. You all have the handout that has  
18 the material that she will be talking about now.

19 So I think -- like I said, the technology's worked out  
20 and Suzanne, I think we're all ready. If you want to say any  
21 other additional words of explanation or introduction for  
22 yourself or for Catalyst for Payment Reform, please feel free  
23 to do that and then we will be ready.

24 DR. DELBANCO: Well, thank you so much and I'm sorry not  
25 to be there with you in person, in part because it's always

1 nice to see people face to face, but also because I've been to  
2 48 states, but I have not yet been to Alaska and I'm so  
3 wanting to go.

4 So anyway, it's a pleasure to connect with all of you  
5 today and I'm going to spend probably about 20, 25 minutes  
6 sharing with you a little bit of background about Catalyst for  
7 Payment Reform so you can understand the perspective that I'm  
8 coming from, but then get right into price transparency as an  
9 issue and also our state report card on price transparency  
10 laws and wrap it up with some thoughts about how you all might  
11 proceed in pursuing that agenda in Alaska and then, of course,  
12 I'd be happy to take questions and get your input, and you  
13 know, see how else we can be helpful.

14 So without any further adieu, I'll tell you a little bit  
15 more about Catalyst for Payment Reform. We are an independent  
16 nonprofit organization and our main constituency is a group of  
17 large employers and other health care purchasers who share the  
18 goal of wanting a higher value healthcare system, better  
19 quality, more affordable care and they all share the thought  
20 that changing the way we pay for care is probably an important  
21 lever to take advantage of.

22 So you can see our members listed here. I'll just point  
23 out, you know, that we've got eight states -- eight state  
24 agencies involved, including Medicaid agencies from four  
25 states, several state employee and some retiree agencies and

1 so it really is a cross-sector effort and has been very  
2 fruitful, you know, to get the enthusiasm and support and  
3 effort of all of these purchasers together, because it really  
4 does take a critical mass of those who want to change the  
5 healthcare system to make that change happen.

6 So with that in the backdrop in terms of who we are, we  
7 have three different ways that we try to accomplish our goals.  
8 I think the bulk of our time is spent in helping employers and  
9 other big health care purchasers use their position on the  
10 sort of buy side of the market, if you will, to signal to all  
11 the other stakeholders that what they're looking for is better  
12 value for every health care dollar they spend and many of  
13 them, of course, rely on health plans to implement what it is  
14 that they're looking for and so we spend a lot of time helping  
15 them in the health plan sourcing process, you know, figuring  
16 out which health plan partner they want, helping them with the  
17 contracting with that health plan, as well as the management  
18 of that health plan over time, all related to their efforts on  
19 payment reform, as well as a few special initiatives that  
20 we've taken on where we think we can make real progress in the  
21 next couple of years and that's really where price  
22 transparency comes in.

23 When we looked at the opportunities before us and what  
24 we'd need to -- in order to take steps forward to a higher  
25 value healthcare system, I think there's not a single one of

1 our members, including the Medicaid agencies, who feels that  
2 we can get to a high value system without greater  
3 transparency, both on quality and on price, and so that's a  
4 theme throughout everything we do, from the questions we help  
5 our members propose to health plans when they're trying to  
6 decide who to work with, to the contract provisions, to the  
7 kinds of updates we ask for from them on a quarterly basis, et  
8 cetera and so again, much of what we do is helping our members  
9 in their sort of market based activity.

10 We also do work, though, to help everyone understand why  
11 it is we think we need to change the way we pay for health  
12 care and some other fundamental reforms to the healthcare  
13 system and so we have a variety of activities, from our  
14 national scorecard on payment reform to some of the attention  
15 we've been trying to raise the issue of healthcare provider  
16 consolidation and market power and what that's doing to price  
17 and it's inter-relation with price transparency and then on a  
18 policy front, we've, again, touched on a variety of issues,  
19 including price transparency.

20 So that's just a little bit of background. Maybe I  
21 should pause there just for a moment to see if there's any  
22 questions specifically about the organization before I get  
23 into the topic.

24 CHAIR HURLBURT: I don't see any here.

25 DR. DELBANCO: Okay, without any questions then, I'll

1 share with you what I plan to cover. So I'm going to talk  
2 about why CPR has chosen price transparency as the topic now.  
3 I mean, I think this is something we could have been talking  
4 about 20 years ago, but we weren't. So why is this a hot  
5 topic now? What is it that we need from it? What's being  
6 done today already and what are some of the challenges?

7 Then, I'll share with a little bit about some of the work  
8 that we're doing to advance transparency and then turn to the  
9 state law report card where we can get into some ideas for  
10 what states can do.

11 So in terms of why price transparency now, I think this  
12 is a fascinating question. I mean, everyone has always felt  
13 that health care was too expensive and we've known for a while  
14 that consumers have really been in the dark when it comes to  
15 making smart health care choices, but I think this is a topic  
16 that's reached its moment because we've never, you know,  
17 gotten to such a paying point before in terms of health care  
18 costs and in particular, employers and other purchasers are  
19 now turning to their enrollees or the consumers in a greater  
20 way that they've ever done before to take on a greater share  
21 of that cost and also implementing benefit plans and designs  
22 that really do put them more in the role of having to make  
23 decisions about how to use their own resources and those --  
24 and the resources that the purchaser is giving them for their  
25 health care benefit.

1           So it's just a different dynamic. Even though not  
2 everybody feels, you know, that need to be financially  
3 responsible with health care yet, some of us still have health  
4 plan designs that really insulate us from the different costs  
5 of our choices we have. I think more and more are in a  
6 position where they really do feel it and need information.

7           I think employers and other purchasers also think that  
8 pressure from consumers is a powerful and underused lever for  
9 change, for demanding, you know, better quality and greater  
10 efficiency, but in order for the strategy to succeed, you  
11 know, we need price transparency.

12           We need people to understand that not all health care is  
13 priced the same way. Not all health care has the same level  
14 of quality, and in fact, there's almost no correlation between  
15 the price and quality of care right now.

16           It's really the unwarranted price variation that's out  
17 there is unwarranted because it's not related to quality, but  
18 it's much more often related to provider market power or other  
19 dynamics in the healthcare marketplace than it is to anything  
20 related to the value of the care.

21           So for all of these reasons, I think price transparency  
22 has really hit its moment and for those of you who don't know  
23 much about how much payment varies, at least in the private  
24 sector, when it comes to how much we pay different providers  
25 for the same service, either within or across markets, we

1 actually had commissioned a study in 2010 that was done by the  
2 Center for Studying Health System Change, a nonprofit  
3 organization, where they looked at commercial data from three  
4 big health plans within and across eight markets and found as  
5 a comparison to the Medicare rates, that there was a huge  
6 variation.

7 I mean, in the state where I live, California, you know,  
8 the difference in what you pay in San Francisco versus Los  
9 Angeles is quite enormous and then just within Los Angeles  
10 itself, you can see that there's a huge range in what  
11 hospitals are being paid for the same service just within the  
12 same market.

13 So again, you know, as many studies as people have done  
14 on this, they have yet to find that it's really correlated to  
15 quality and so the more, I think, people are educated about  
16 this, the more, I think, they realize that not only is our  
17 pricing system, you know, far from sort of rational, but it's  
18 also something that we really need to bring to the consumer so  
19 they can understand that not all their choices are the same,  
20 not all of them have the same impact on spending.

21 So before we get too far, I think it's always important  
22 to define terms. We've actually adopted the definition of  
23 price transparency and price that was authored by the General  
24 Accountability Office of the U.S. federal government and they  
25 basically describe price transparency as the availability of

1 provider specific information on the price for a specific  
2 health care service or set of services to consumers or other  
3 interested parties.

4 I'm not going to read you the whole definition of price,  
5 but I think the important thing to note here is that we and  
6 they define price as what impacts the consumer. What is the  
7 consumer's ultimate cost in seeking health care from one  
8 provider versus another, or even one procedure versus another,  
9 and you know, looking at it from the consumer angle is really  
10 where our focus is.

11 So you know, there's a lot of discussion and debate,  
12 what's the difference between price and charge and cost, we're  
13 really, again, here focused on price from the perspective of  
14 what the consumer pays. Should I pause and just see any  
15 questions yet?

16 All right, so the other thing I was going to point out is  
17 that as you've heard me make the point, since there's very  
18 little relationship right now between price and quality, we  
19 think it's really important to combine information about those  
20 two aspects of care in one place and that it would be very  
21 misleading if we don't, because I think many of us might  
22 assume that more expensive care is better care, when in fact,  
23 the opposite could be true and so it's going to be very  
24 important over time for us to figure out what are the most  
25 important quality measures? What is the price information,

1 and how can we digest that in a way that's really  
2 understandable to the consumer?

3 Kind of like when you go into the grocery store and  
4 there's signs pointing you to the best deals and the best  
5 value, you know, or consumer reports -- does that for, you  
6 know, its reviews. I think we're going to need to find a way  
7 to digest these very complex, you know, dimensions into  
8 something that's digestible and useable by the average  
9 consumer.

10 So you know, the other reason we think transparency is  
11 important, because you know, information itself doesn't really  
12 often change behavior, you know, maybe in the case of price  
13 transparency, it would be more likely to change providers'  
14 behavior than even the consumer, because if you just throw  
15 information at people, they rarely act on it or change the  
16 behavior act -- you know, on it.

17 They need other incentives and so, of course, many of the  
18 private employers are beginning to experiment with different  
19 types of benefit designs that do create incentives for  
20 consumers to choose the more value oriented options and that's  
21 being done through benefit design, even through network  
22 design, where employers are looking at creating, you know,  
23 high performance networks or narrow networks of providers that  
24 meet certain criteria on the quality and cost dimensions.

25 So anyway, price transparency is not just, you know,

1 something that is the right thing to do because consumers have  
2 the right to know, but also because it's a building block for  
3 some of the more promising strategies that employers can  
4 implement today.

5 So what's happening to promote price transparency now?  
6 You know, everyone's kind of getting in on the act, which is a  
7 good thing. You know, 34 states today currently require  
8 reporting of hospital charges or reimbursement rates.

9 Some states have gone pretty far in making sure that  
10 consumers get the information they need and that it's easy to  
11 find and use and relevant to them and I'll get into more  
12 detail about that in our report card results.

13 The federal government, you know, has different efforts.  
14 They, you know, for drug costs, they've had an online tool for  
15 a while where beneficiaries can calculate their expected out-  
16 of-pocket drug costs. You know, of course, they have some  
17 quality sites now, like Hospitalcompare.gov and  
18 physiciancompare.gov, where there's comparative quality  
19 information.

20 Although, my critique of those would be that many of the  
21 measures they've chosen to focus on are ones that are unlikely  
22 to show a lot of differentiation among providers and so  
23 they're not that helpful in helping consumers pick and choose.

24 Then in the private sector, almost every health plan has  
25 some kind of cost calculator tool now and there are also a

1 growing number of independent vendors in this space, like  
2 Castlight Health or Change Health Care and others, who are  
3 trying to master, you know, the right way of conveying this  
4 information to consumers.

5 The tools certainly vary a lot in their functionality and  
6 their availability and we'll get into some more of that as we  
7 go through this discussion.

8 There are a lot of challenges to price transparency right  
9 now. In areas where there's not much competition among  
10 providers, providers are in a position to refuse to reveal  
11 their pricing information and you may have heard of clauses  
12 that are put into contracts sometimes between health care  
13 providers and health plans where the health care provider  
14 says, "You know, if you want to do business with me, you have  
15 to promise not to reveal any information about what you're  
16 paying me, even if it's just to relate it to the consumer in  
17 terms of their out-of-pocket costs," and then health plans  
18 also put some restrictions on employers' use of price data,  
19 feeling that the amount that they pay to providers is  
20 proprietary and therefore, they don't want the employer to  
21 take their own claims data, even the self-insured employer,  
22 who, you know, takes on the insurance risk and just uses the  
23 health plan as an administrative support, they're not allowed  
24 to take their claims data and give it to a third-party vendor,  
25 who, you know, who they might think is better suited to make a

1 transparency tool for their population, and you know, of  
2 course, other challenges relate to the fact that we have a lot  
3 of work to do to educate, you know, the average citizen about  
4 health care costs and health care quality and how to make good  
5 decisions.

6 There's also some concern on the part of economists about  
7 what happens when you start making price information more  
8 transparent. You know, are we going to see prices rise? Are  
9 they going to lower? Is there going to be greater or less  
10 variation, and these are empirical questions that we obviously  
11 need to answer.

12 So you know, there's nuances that have to be taken into  
13 account here, you know, details really matter in terms of how  
14 the information gets conveyed and who gets to see it and how  
15 it's used.

16 I mentioned before that we found that almost every health  
17 plan now does have some kind of cost calculator tool. I think  
18 what's important to point out is that they can be very hard to  
19 find and very, you know, unfriendly to users and so at the  
20 same time, we see that only 2% of total enrollment actually  
21 use the tools. So there's a big mismatch there and we think  
22 that it's going to be important for tools, you know, to get  
23 much more useable over time.

24 So related to that, we put out a series of specifications  
25 or features that we think, that you know, consumer

1 transparency tools really have to have to be meaningful and  
2 useable and these really relate a lot to how we then judge the  
3 different state laws in how far they went to ensure that  
4 citizens had access to pricing information, because really  
5 what we're getting at is, you know, what's the scope of the  
6 information provided?

7 Does it touch on most of the procedures and services and  
8 providers that consumers want to know about? Does it give  
9 them information that's really meaningful to them about what  
10 their out-of-pocket exposure is going to be, and you know, how  
11 easy is the information to find and customize and use and  
12 understand, and you know, again, you'll see that this set of  
13 specifications is really echoed in the criteria we use to  
14 grade the states.

15 This is a document that's available on our website. You  
16 can download it free of charge and it just gives you, I think,  
17 a feel for the kinds of things that tools can provide now.  
18 These are all features we've seen somewhere, but very few  
19 tools, including the state tools that have been developed, you  
20 know, meet all of these specifications today.

21 Then, you know, I think this is an area where advocacy is  
22 really important. It's very easy in health care to kind of  
23 stick with inertia and not change the status quo. So we have  
24 felt it's been an important topic to be vocal about and so we  
25 did put out a statement last November that was undersigned by

1 many different organizations from the business and labor and  
2 consumer space saying that we would really like health plans  
3 and providers to cooperate and make transparency a reality and  
4 that, you know, the truth is in the private sector on a  
5 voluntary basis, the healthcare industry really could make  
6 price transparency a reality for almost everybody except for  
7 the uninsured, meaning if people have access to health  
8 insurance one way or the other, you know, there would be a way  
9 through their health plans or whoever's providing benefits to  
10 them to share price information.

11 So we'd like to see the private sector really step up and  
12 do a lot more, but where they're not going to meet everybody's  
13 needs or where there's resistance, you know, there can be a  
14 role for the state to step in and so now, I was going to make  
15 the transition to our state report card, but let me just pause  
16 and see if there are any other questions I should answer  
17 (indiscernible - interference with speaker-phone) continuing  
18 and can you guys still hear me all right?

19 CHAIR HURLBURT: Yes, doing just fine, thank you.

20 DR. DELBANCO: Just wanted to check. Okay, so our state  
21 report card on price transparency laws, we actually did in  
22 partnership with another nonprofit organization called the  
23 Health Care Incentives Improvement Institute.

24 We found out through our relationship with each other  
25 that we were both sort of working on the same thing at the

1 same time. So we decided to work together. I had actually  
2 been asked by the insurance commissioner of California if I  
3 had ideas for him from other states of what he could advocate  
4 for within California to support price transparency.

5 So it led us off on the path of doing some research about  
6 what kinds of laws other states have passed to ensure that  
7 citizens had access to pricing information. So the goal of  
8 the project was to really understand what these other laws  
9 entailed, whether or not we thought they really provided  
10 assurance that consumers would get the information they need  
11 and also as a way to kind of just, again, as per our strategy,  
12 shining the light on the topic on the need for more action and  
13 effort and to identify the fact that we'd like the private  
14 sector to really step it up, but you know, where it's needed,  
15 there's also a role for states.

16 So the first thing we did was to review all the state  
17 laws that were on the books. You can see a little commentary  
18 here on methodology that we used, that we tried to really be  
19 as comprehensive as we could, not to miss anything, but I will  
20 say here that all we were looking at were laws that had been  
21 passed and so there definitely is activity that can occur at  
22 the state level, but is not going to be reflected in a law.

23 There might be voluntary activity going on. There might  
24 be some regulations that have, you know, put something  
25 underway and so that is one limitation of our study, which is

1 that we really only looked at state laws that had been passed  
2 and then the grading criteria, again, echo really some  
3 comments I made earlier, which is we wanted to look at to what  
4 degree the laws made sure that there was enough breadth of  
5 information, both in terms of the scope of services and the  
6 providers.

7 We wanted to make sure that the price information was  
8 relevant. So you know, you've heard probably some stuff in  
9 the news recently about the Medicare program releasing charge  
10 information, meaning what kinds of bills were they sent by  
11 hospital, but we know that's really not what anybody  
12 ultimately pays.

13 It's, you know, whether it's Medicare or Medicaid or  
14 private health payers, you know, everybody's got some kind of  
15 rate they've set or negotiated agreement that is usually  
16 something less than that charge master. So we wanted to see  
17 if they were really -- these state laws really making sure  
18 that the information being projected to the consumer was  
19 relevant.

20 Then we looked to see how transparent the information  
21 was. Some state laws really just say, you know, report  
22 information into the state. It goes into sort of a black hole  
23 and nobody ever sees it again. Some states passed laws just  
24 saying that providers were required, upon request, to help a  
25 prospective patient estimate their cost.

1           Some states required that there be a report done once a  
2 year, you know, some very thick file that maybe listed all the  
3 hospital charge masters or something like that. So it was a,  
4 you know, a very thick report that might be posted on a  
5 website somewhere.

6           Then some states went farther and created websites that  
7 were meant to be consumer friendly and even potentially  
8 customizable where a consumer could actually say, you know,  
9 what my health plan is and what my benefit design is and  
10 therefore, get a, you know, a fairly accurate estimate of what  
11 a given choice might mean in terms of the implications for  
12 their financial exposure, you know, from one provider to  
13 another.

14           So these are the criteria we used to grade the different  
15 states and their laws and we wanted to put out two different  
16 resources, the report card itself, but also a reference table.  
17 So for in your example, if you want to see what it was we used  
18 to come up with these grades and which exact laws we found and  
19 even hyperlinks to those laws, we've created a reference table  
20 that we hope will be useful.

21           So in -- all of that as background, we found two states  
22 were worthy of giving an A in this first go around and we did  
23 have to grade on a curve. So these two states that got A's  
24 were in the 60's in terms of the percent of criteria that they  
25 met that we had established with our grading process.

1           So you can see we were grading on a curve, but both  
2 Massachusetts and New Hampshire are really making a go at  
3 trying to get information to people that's really relevant to  
4 them and that's fairly comprehensive.

5           So these are two websites that I recommend you guys take  
6 a look at, MyHealthCareOptions for Massachusetts and New  
7 Hampshire health cost. They are probably, you know, we think  
8 the two most exemplary options out there and I'm sure many  
9 other states are going to be taking a look at what they're  
10 doing and I'm sure both of these states are going to continue  
11 to work and make these better, because they're not perfect  
12 yet, but what we found across the country, you guys shouldn't  
13 feel bad, most of the states got the lowest possible grade  
14 because in many cases, like yours, there just weren't any laws  
15 passed at all.

16           In some cases, states received F's. They might have had  
17 a law passed, but it just met so few of our criteria that it  
18 didn't find it's way to a high enough percent of a score that  
19 it could get a grade above an F and you can see, very few  
20 states really did, you know, were in the A and B range and  
21 even the C range.

22           So we weren't doing this to be negative, it was just more  
23 to show the, I guess wide range of activity, in terms of laws  
24 that have been passed and what states were doing and we  
25 created a reference table, and I'm just showing an example

1 here from New Hampshire, because since, at least according to  
2 our research, we didn't find any laws passed in Alaska, I just  
3 thought the New Hampshire example might be helpful because  
4 they did well and you can see the kinds of information we  
5 share in the reference table, the state, the name of the laws  
6 themselves and hyperlinks to them, what year they were passed  
7 and then according to our criteria, what were the excerpts  
8 from those laws, you know, that were most relevant as someone  
9 looking at a glance.

10 Then we also created a summary table and this -- I just  
11 chose the first three states in the alphabet to capture here  
12 and you can see the grade is on the far right and then in the  
13 Arkansas example, you can see where there are checkmarks where  
14 their state laws, you know, got some creditor points, if you  
15 will, because for example, in the case of Arkansas, there is,  
16 you know, some practitioner information being provided.

17 It's just charge information and it's for a small subset  
18 of services that's -- you know, so again, it didn't get a  
19 great grade, but it did get some points for having laws on the  
20 books that were addressing some of this.

21 So just to get to, you know, where I think we can start  
22 off your discussion, you know, I think the implications are  
23 that, for the most part, you know, the average citizen in this  
24 country right now can't depend on state laws to ensure that  
25 they have information that they need.

1           You know, this may involve -- I think we'll see states  
2 address this more. We also think we're going to see the  
3 private sector continuing to try to step up to meet this  
4 challenge, but I think the lesson for all of us is that  
5 information alone, you know, is not going to change behavior,  
6 but it is a really important building block.

7           So just some initial ideas that I just threw out for  
8 discussion about how, you know, you could advance transparency  
9 in Alaska, you know, obviously, there can be an advantage, and  
10 I don't know to what degree you guys are involved in trying to  
11 create an all-payer claims database and I'm sorry, I didn't  
12 have research. I didn't have time to do research to know  
13 where this might stand in your state, but there are obviously  
14 examples now in states where they're trying to pool data  
15 together from both commercial payers, as well as the public  
16 sector payers to get a better handle on the practice patterns  
17 and referral patterns and quality and in some cases, payment  
18 variation and depending on how an all-payer claims database is  
19 set up, it really can become the database, if you will, behind  
20 price transparency information for consumers.

21           You know, it's also, you know, a high bar, but you know,  
22 there -- you could take a look at the examples of the states  
23 that we thought did well, Massachusetts and New Hampshire, and  
24 try to, you know, put laws in place that there's price  
25 information available to consumers on, you know, as broad a

1 range of services and providers as possible, on price  
2 information, as opposed to just charge information, and in,  
3 you know, a very accessible manner like a customizable  
4 website.

5 I think another thing that we've seen some states do is  
6 to try to prohibit what we call gag clauses where providers,  
7 especially those with market power, really restrict the use of  
8 information about what they're paid and therefore, leave  
9 gaping holes, you know, in some markets that are particularly  
10 affected by this, you know, and the information that consumers  
11 need.

12 There's also a tie-in here to payment reform. One of the  
13 tricky things about price transparency, when we're all still  
14 paying so much fee for service is that the typical consumer  
15 has no idea what, you know, CPT codes are going to go into  
16 taking care of them for a given need that they have and so as  
17 we see more experimentation with bundled payments, another  
18 appeal that it has, you know, when there's a single payment  
19 for an entire episode of care, is that it could, you know, be  
20 helpful to the consumer in understanding what they're likely  
21 to have to pay for everything they need without having to try  
22 to figure out how to add together a whole bunch of individual  
23 services that frankly, only a doctor or a hospital  
24 administrator might be able to put together.

25 Then, you know, again, I hope my understanding is

1 correct, but I think Alaska is going to be having a federally  
2 facilitated health care exchange and it's possible, you know,  
3 that the federal government will put some price transparency  
4 requirements in there for the participating and qualified  
5 health plans. That's another route that things could go.

6 Then of course, you know, Alaska has state employees and  
7 retirees, and you know, the Division of Retirement and  
8 Benefits could, through its own purchasing practices, require  
9 its partners, both in the health plan space and the provider  
10 space, you know, to support price transparency for state  
11 employees and retirees.

12 So those are just, you know, initial sort of a brainstorm  
13 list of things that you guys could contemplate and discuss.  
14 So that's the end of my formal remarks, but I'm available, you  
15 know, for the next 30 minutes to, you know, to chat with you  
16 guys about any questions or comments or thoughts you might  
17 have.

18 CHAIR HURLBURT: If you have questions, just introduce  
19 yourself to Suzanne.

20 COMMISSIONER HARRELL: Yes, ma'am, I am Dr. Harrell. I'm  
21 the Commander of the military hospital here in Anchorage. A  
22 couple of questions, if I may? One of our previous presenters  
23 this morning commented also on the New Hampshire and the Maine  
24 databases, their programs, their websites, but if I recall  
25 correctly, also mentioned they are not being heavily used by

1 consumers and so I'm curious.....

2 DR. DELBANCO: Right.

3 COMMISSIONER HARRELL: .....if you have had -- so you've  
4 had that same experience. Comments on that, and then I have a  
5 follow-up question, as well.

6 DR. DELBANCO: Yeah (affirmative), so that goes back to  
7 the point I was trying to make before, which is that  
8 information alone doesn't change behavior. So if you have no  
9 reason to look at prices because your health insurance, you  
10 know, benefits are designed in such a way that you're going to  
11 pay the same co-pay no matter where you go, there's not really  
12 much reason why you would go look there, I mean, unless you're  
13 just a curious person, or you know, a health policy person,  
14 like me, and you know, you just want to know.

15 So I think that really how we're thinking about price  
16 transparency now is we're laying a building block for what we  
17 think is going to be a rapidly changing situation for many of  
18 us in terms of how we receive our health care benefits and how  
19 they're designed, where, you know, our share in, you know, the  
20 size of our deductible might be much larger or we might be  
21 going from, you know, a flat co-pay to more of a co-insurance  
22 model.

23 There's all kinds of changes that I think employers are  
24 turning to as a way of trying to get their costs more under  
25 control and help, you know, having their enrollees be part of

1 the solution.

2 So the fact that few people are using it right now is  
3 really consistent with the finding we had, I think. I'll flip  
4 back up to that slide from our national score card on payment  
5 reform where we had many health plans report to us. You know,  
6 98% of them offer or support a cost calculator, but only 2% of  
7 enrollment was using it.

8 So it doesn't surprise me at all. It doesn't mean it's  
9 not important to have those tools, because I think there's  
10 going to be more and more reliance on them pretty quickly here  
11 over the next few years.

12 COMMISSIONER HARRELL: Thank you. I'd like to follow up  
13 regarding the cost of this. We've also had presenters this  
14 morning talk about the costs that are going to be generated  
15 that are related to collecting this data and some have  
16 proposed that there is going to be a cut line that needs to be  
17 imposed such that larger organizations may be able to absorb  
18 the cost to be able to collect, generate this data and publish  
19 this data, whereas if you move into more of a private office  
20 setting, the cost would be too prohibitive on the individual  
21 providers to engage in that. Your thoughts on that matter.

22 DR. DELBANCO: Yeah (affirmative), you know, to be  
23 honest, this is a little bit out of my area of expertise in  
24 terms of the mechanics of putting these kinds of things  
25 together. I would personally recommend, you know, and I don't

1 know who else -- I know you guys sent me the agenda. I didn't  
2 have a chance to see your speakers were this morning, but you  
3 know, whether it's the group CIVHC in Colorado that's putting  
4 together the all-payer claims database with this goal in mind  
5 or others, I would turn to them to understand how exactly  
6 they're gathering the data from providers and then, you know,  
7 what it's going to cost them to analyze it and sort of spit it  
8 back out in a way that's useable by consumers.

9 COMMISSIONER HARRELL: Okay, and if I may, my colleagues,  
10 one final question. If I forced you to choose between an  
11 outcome for what you think is the most benefit in  
12 transparency, would you pick cost or health care outcome?

13 DR. DELBANCO: Please don't force me. I mean, I guess,  
14 you know, when I think about what matters most to consumers,  
15 you know, I think it's a hard call right now. I mean, much of  
16 my career, I have worked on transparency related to quality.

17 So my immediate thought is to go there, because frankly,  
18 you know, all of us want to know how we're likely to fair, not  
19 only based on our own personal circumstances and health care  
20 challenges, but also based on the providers we choose, but  
21 more and more, health care is eating up the average American  
22 family's income.

23 You know, it represents, you know, premiums represent  
24 about 20% of the average American family's income. So you  
25 know, the cost issue is becoming really serious. So I'm not

1 trying to dodge the question at all. I think, you know, like  
2 I said, my gut is to go to quality first and outcomes first,  
3 but financially, it's becoming a very serious matter for most  
4 American households and so I don't think that we can ignore  
5 that.

6 CHAIR HURLBURT: Suzanne, this is Ward Hurlburt. I'm the  
7 Chair of the Health Care Commission here and you're preaching  
8 to the audience as far as the need for transparency as  
9 something the Health Care Commission has agreed upon.

10 DR. DELBANCO: Right.

11 CHAIR HURLBURT: But based on what we've heard, and this  
12 morning we did hear from Patrick Miller at the University of  
13 New Hampshire there talking about all-payer claims databases.  
14 We have contracted with Freedman Associates out of Boston that  
15 have helped educate us and provide some information on that,  
16 so that we have been looking at an all-payer claims database,  
17 but consistent with your slide number 11 there, showing only  
18 2% of consumers using it, that's the information that we've  
19 received from Freedman and from the others that we've talked  
20 with and there is a cost implementing an all-payer claims  
21 database and I think intellectually we could agree with your  
22 comments that this would be laying the groundwork as we move  
23 toward more consumer involvement, but as a state, where there  
24 would be a significant cost, as well as legislation to set  
25 this up, so to include the ERISA type insurers, we are

1 entering an economic cycle that most other states entered four  
2 or five years ago that.....

3 DR. DELBANCO: Right.

4 CHAIR HURLBURT: We're -- we're looking where we can't  
5 spend as much money as we have been spending and our payments  
6 are going to go down. So in that kind of an environment,  
7 where obviously, you're very much an evangelist about all-  
8 payer claims databases and what we're saying at this point, we  
9 don't see where it is making a difference in these dozen or so  
10 states that are at various stages of implementing it, how  
11 would you kind of respond to that?

12 DR. DELBANCO: Yeah (affirmative), I mean, you know, all  
13 of us, whether it's in our own household budgets, or you know,  
14 in the budget of a state have to make tradeoffs and decide  
15 what's the right investment for the, you know, return, and you  
16 know, I think I would probably be pondering the same question  
17 if I were all of you. Is it worthwhile making this investment  
18 now for some future payoff that seems uncertain to us based on  
19 the current usage?

20 You know, there are other smaller things that you could  
21 do, and by no means trivial things, that I think could also  
22 foster transparency without going all the way to an all-payer  
23 claims database. Some of the barriers that I mentioned that  
24 are happening in the private sector could be something that  
25 you address and I don't know, you know, to what degree the

1 plans that are dominant in Alaska are doing in terms of their  
2 price transparency efforts and support for consumers, but you  
3 know, that's probably the first place I would look and look to  
4 see if there are any real stumbling blocks like these gag  
5 clauses I mentioned, or you know, health plans view of their  
6 payment information as being proprietary and see if there  
7 could be some tinkering there, so that at least those in the  
8 commercial sector with insurance could have some  
9 (indiscernible - interference with speaker-phone) removed to  
10 either their health plans or their employers, you know,  
11 helping foster price transparency there.

12 I think that could be true for state employees as well,  
13 and you know, things like that, that are much more pointed and  
14 targeted, I still think could help advance things, you know,  
15 perhaps beyond where they are today, and you know, again, I  
16 think starting with New Hampshire, a discussion is a great  
17 idea. I would recommend you talk to Colorado. I'm sure there  
18 are, you know, others states I should mention you -- it sounds  
19 like you talked to Maine, as well, and just hear, you know,  
20 the staging of their efforts because it is a huge endeavor.

21 It takes a lot of cooperation from many parties and it  
22 takes, you know, time. I think the tricky thing with health  
23 care sometimes is that it moves so slowly. It evolves so  
24 slowly that sometimes I feel like we can all have a crystal  
25 ball and see where it's going and personally, I can't imagine

1 a future, you know, a future health care system that doesn't  
2 have much greater quality and price transparency.

3 So I guess it's the question about when is the right  
4 moment to make that investment if we are pretty sure that's  
5 where it's headed and then it's really a question of how  
6 quickly. So I don't know if that helps you, but that's sort  
7 of how I think about approaching your answer.

8 CHAIR HURLBURT: Thank you, Suzanne. Yes, Tom, I think  
9 you had another comment or question?

10 COMMISSIONER HARRELL: (Indiscernible - too far from  
11 microphone).

12 CHAIR HURLBURT: Okay. Others? Yes.

13 COMMISSIONER STINSON: Just a housekeeping issue, one of  
14 these slides says, "Do not distribute." Are these not for --  
15 can we not take these home to our.....

16 DR. DELBANCO: No, these -- I think, sorry, that was -- I  
17 was pulling slides together from a variety of presentations.  
18 I think everything here is fine to distribute.

19 CHAIR HURLBURT: Yes.

20 COMMISSIONER DAVIS: Hi, Suzanne, my name is Jeff Davis  
21 and I'm representing health insurers on the Commission. Just  
22 to explore a little further, we've talked today about all-  
23 payer claims databases. We also talked about sort of an  
24 expansion of the hospital discharge database that's currently  
25 in existence to capture more services.

1           Just on the face of it, it seems that the -- expanding  
2 the service database is simpler and less expensive than  
3 expanding the all-payer claims database. I just wondered if  
4 you had any experience or observations or thoughts on the  
5 relative utility of those two and if that might -- if the  
6 service database might help us down this road as well? Thank  
7 you.

8           DR. DELBANCO: Yeah (affirmative), I mean, I think, you  
9 know, the thing about data is always that you have to be sure  
10 you know what it is you want to use it for at the end of the  
11 day and so I think the best way to answer that question is to  
12 know where it is you're heading.

13           I think discharge data can be incredibly useful in  
14 understanding practice patterns, in variation across practice  
15 patterns, you know, among providers. It can be helpful on  
16 some level on quality measurement. It can be certainly  
17 helpful to some degree in terms of maybe measuring some  
18 efficiency, but it's not going to ultimately help consumers  
19 understand what their costs are.

20           So it really just depends, you know, what it's for. I  
21 think far too often in health care, we collect things because  
22 we think it's interesting, but we don't really have a clear  
23 purpose for it at the end of the day, or you know, we don't  
24 choose it because of its ultimate utility and so talk about,  
25 you know, limited resources, I guess I would want to make sure

1 it was going to really meet the needs or not bother.

2 COMMISSIONER DAVIS: Thank you. This is Jeff again, just  
3 following up. That's, I think, really the crux of the matter  
4 that we're struggling with is -- I think we know we want to  
5 get to meaningful cost and quality transparency. We believe  
6 that is a transformation. I agree with you that unleashing  
7 the power of the consumer will go a long ways toward helping  
8 to drive out the 30% of what's done that's pure waste, 30 to  
9 40%, but it is -- so it's that utility, and the question is;  
10 an all-payer claims database with the investment and time and  
11 money that it would take, what's your confidence level that  
12 would -- that's the best means to head down a road to  
13 meaningful cost and quality transparency?

14 DR. DELBANCO: Yeah (affirmative), so I mean, I think  
15 there are a lot of things that an all-payer claims database  
16 can bring you. So it gives you a much greater sample size to  
17 measure quality, especially at the physician level. So  
18 hospital quality measurement hasn't been too hard, because  
19 there tends to be some volume there, but you know, at the  
20 physician level, it can be very challenging if you don't  
21 combine data across payers and especially in a state like  
22 Alaska where there are rural areas, and you know, you're  
23 really trying to get a good picture of a provider, if you  
24 don't combine all the data, it can be very difficult, if not  
25 impossible to come up with a statistically accurate view of

1 what's happening from a quality or a process, or you know,  
2 practice pattern perspective.

3 So I think, you know, from a quality measurement side,  
4 you know, there's a very strong argument. I think when it  
5 comes to understanding health care spending and costs and  
6 what's driving those costs, having pool data can also be very  
7 important.

8 Though, I would argue that the state, itself, when it  
9 purchases for state employees or retirees or individual  
10 employers who have access to their claims data, can probably  
11 analyze that on their own for their own population, and you  
12 know, and get a decent handle on what they're spending, you  
13 know, what they're spending the bulk of their money on and  
14 where, and you know, I've worked with some employers, for  
15 example, who are identifying, you know, maybe the 10 providers  
16 most responsible for driving costs, and you know, eliminating  
17 them out of their network and not even covering them as an  
18 out-of-network provider anymore.

19 You know, there's analysis that a purchaser can do at an  
20 individual level that can get them somewhere, but if you want  
21 to start looking at sort of macro trends and understanding  
22 what's happening in your state from, you know, the perspective  
23 of provider relationships and their -- and that connection to  
24 cost or to price and to what degree is price driving health  
25 care costs up versus utilization or intensity or things like

1 that, you know, you really need a big database that pools data  
2 from all these different sources together to be able to look  
3 at those trends and those patterns, and then at the end of the  
4 day, of course, going back to the New Hampshire example, you  
5 know, to ultimately help the average consumer who comes to a  
6 website, let's say it's run by the state of Alaska and you  
7 want to know how much it's going to cost you, you know, Jeff  
8 Davis, to get a procedure here versus there and you can put in  
9 your health plan information and it pops out for you a pretty  
10 decent, you know, estimate based on your coverage, you know,  
11 that's, again, going to require lots of different data sources  
12 pooled together, but if you've got commercial coverage, and  
13 you know, your plan already does that, you know, it's probably  
14 not going to add that much utility to you on the price  
15 perspective.

16 So that was probably a long-winded answer to your  
17 question, but it's just sort of me thinking out loud about  
18 some of the things it gets you and some of the things, that  
19 you know, could probably be handled elsewhere.

20 COMMISSIONER DAVIS: Yeah (affirmative), thank you very  
21 much. I appreciate that. Thanks.

22 MS. ERICKSON: Hi, Suzanne, this is Deb.

23 DR. DELBANCO: Hi.

24 MS. ERICKSON: I was wondering, the two states that got  
25 an A on the state transparency law report card both provided

1 information to consumers on a public website and both, if I  
2 understand correctly, gather that data from the all-payer  
3 claims database. Is that correct?

4 DR. DELBANCO: That's my understanding of it. My -- yes.

5 MS. ERICKSON: Okay. So I'm wondering, one of the other  
6 options the Commission might be considering that isn't -- it's  
7 not usually exclusive with an all-payer claims database and we  
8 actually had a consumer come to our last meeting and make a  
9 request that the Commission consider compelling providers to  
10 make their prices more transparent and so do you have -- do  
11 you know of any, I don't know if you'd consider it best  
12 practices if there are no other states that got an A, maybe  
13 not, but some of the state laws that you looked at that  
14 weren't using the all-payer claims database, but were laws  
15 that required health care providers to make their prices more  
16 transparent, do you know, are there any of those that you  
17 would consider a best practice or would you have any  
18 recommendations about that approach?

19 DR. DELBANCO: You know, I can ask my staff, who did the  
20 analysis themselves, if any really stuck out to them, but in  
21 the full report itself, in the resource table and in the  
22 summary table, we capture that concept of, you know, was there  
23 a law passed that required providers to provide information  
24 upon request and so it wouldn't take that long to sort of  
25 eyeball, you know, the table and see which states had any law

1 doing that and then, you know, look at the excerpts we put  
2 into that resource table to see, you know, sort of how they  
3 were worded and what the nature of them was, but I'm happy to  
4 take it back to my team and ask them if any of those  
5 particularly stood out, because I do think, you know, here's  
6 the challenge, right, so I don't know how many of you have,  
7 but I certainly have been in a position before where I was  
8 trying to choose a hospital for something and you call up the  
9 main number and you tell the operator what it is you're  
10 looking for and first, they send you, you know, to billing and  
11 they don't know the answer and then they send you to public  
12 affairs and they don't know the answer and either you're sort  
13 of shoved around to the point where you sort of feel like you  
14 have to give up and then you call your health insurance  
15 company and hope they know the answer and it's (indiscernible  
16 - voice lowered) law is on the books, sometimes making it  
17 happen in reality for a consumer, you know, can be very  
18 challenging.

19 So personally, and maybe I'm bringing too much personal  
20 experience into this, I think it's one thing to say that this  
21 must happen, but I could almost imagine that it could be  
22 worthwhile to describe some of the almost customer service  
23 elements of that, that would mean that a hospital was in  
24 compliance so that it would really be accessible to the  
25 consumer.

1           You know, some hospitals have taken it upon themselves to  
2 post their charge masters. Again, you know, it's a nice  
3 gesture, but almost nobody pays what the amount listed in the  
4 charge master, and again, most consumers don't really know  
5 what's involved in their entire episode of care and so  
6 estimating that on their own is really difficult.

7           So I think what it ultimately requires is there to be a  
8 team of people at the hospital who are trained to help figure  
9 out for that perspective patient based on their insurance and  
10 the type of care that they're most likely to need in its  
11 entirety, you know, what their out-of-pocket exposure's going  
12 to be.

13           So the only quick reaction I would give is that I would  
14 want to really think through mechanically what it would entail  
15 for it to be meaningful in reality and then try to incorporate  
16 that into whatever sort of law or regulation I was going to  
17 put out there.

18           CHAIR HURLBURT: Any other questions or comments? Okay,  
19 this was very helpful. Thank you very much, Dr. Delbanco.

20           DR. DELBANCO: My pleasure and we're happy to be a  
21 resource to all of you or be someone who can connect you to  
22 other resources as you guys move forward in your work and I  
23 really commend you for delving into this.

24           CHAIR HURLBURT: I suspect we'll be in contact with you.  
25 I appreciate that.

1 DR. DELBANCO: Okay.

2 CHAIR HURLBURT: Thank you so much.

3 DR. DELBANCO: All right, good luck to you. Yeah

4 (affirmative), bye, bye.

5 CHAIR HURLBURT: Bye. At the time of public comment, Dr.  
6 Farr was -- said that she followed the directions to get in  
7 and make contact and thought she had, but has some comments  
8 that she wants to make, handwritten out so that they're not in  
9 shape to do that and she was kind of frustrated not to be able  
10 to get in.

11 She's seeing patients and so she's going to come back at  
12 3:00. So if we could take a break now, we've got about 10  
13 minutes and then we'll just add that onto the public comment  
14 period and then go into the rest of our program. Thank you.

15 2:50:48

16 (Off record)

17 (On record)

18 3:00:01

19 CHAIR HURLBURT: .....Dr. Farr earlier, I'd like to  
20 repeat that, she did all the things we asked her to do on the  
21 website and on the phone to try to get in, but somehow the  
22 system didn't work and she's had a really busy day in the  
23 office and ran in and ran out and went back and saw some  
24 patients, but that was gracious of her to come back now. So  
25 please, Dr. Farr, if you could share your comments with us?

1 DR. FARR: I'm Ilona Farr, a family practice physician,  
2 and basically, you know, I'm hearing everybody. Everybody  
3 here has good ideas, but my job as a physician is to see  
4 patients. Every one of these things you guys are proposing is  
5 taking me away from patient care and that is what the major  
6 problem is and thus, it is increasing costs.

7 I do a lot of manipulative medicine. The amount of time  
8 that I cannot lay hands on the patient is -- it makes it more  
9 expensive, whether I have to do electronic health records,  
10 whether I have to do quality measures, whether it comes to pay  
11 for performance, the biggest problem that we have right now is  
12 preauthorizations, the amount of time it takes. About 5% of  
13 my office time is taken up with preauthorizations now, which  
14 takes me away from patient care.

15 My overhead is \$475 an hour. I have to make that each  
16 hour in order to function and to pay my employees. I figured  
17 out with the ICD-10 codes that are coming up, that Heritage  
18 did a study, \$283,000 per provider to initiate just the ICD-10  
19 codes, okay. That is going to probably mean that I have to  
20 add one or two more staff people and it's going to be a real  
21 problem, because it's really going to increase my cost and I  
22 figured out I was probably going to go up to about \$600 an  
23 hour.

24 The preauthorizations are a big problem. Part of it is  
25 some insurance companies require preauthorizations and some do

1 not. People change insurance companies all the time. There's  
2 120 different insurance companies that I am dealing with at  
3 any one moment. I cannot keep up with all the formularies. I  
4 cannot keep up whether some insurance companies require MRI  
5 preauthorizations and some do not.

6 The paperwork is all totally different for these  
7 insurance companies. The number I have to call to get  
8 preauthorizations are all different. So I have to have my  
9 nurse call or my front desk staff, to get this information and  
10 then I have to actually manually fill it out. All of these  
11 things increase cost.

12 As an American Academy of Family Practice physician, I've  
13 been to a couple of meetings lately where they've been talking  
14 about medical homes. If you are talking about a medical home,  
15 as me, the primary care physician being in charge of what's  
16 going on and getting -- having a patient evaluated by a  
17 primary care physician before they're referred to a  
18 specialist, then I think you're going to save money.

19 If you are thinking about a medical home as providing a  
20 wide range of services where I have to do Botox injections,  
21 where I have to do skin treatments, which is what some of the  
22 medical home models are in the states to allow them to make  
23 money, because they are getting so under-reimbursed by  
24 Medicaid and Medicare, they have to provide these other  
25 services to just make their clinics work.

1           That takes my time away from patients because it's more  
2 time that I have to oversee people. It's more overhead for me  
3 my job as a physician is to see patients and all of these  
4 things that are being proposed are going to take me away from  
5 patient care and it's very frustrating for me, as a physician,  
6 I did electronic health records 10 years ago.

7           I did them. I survived six months. I was doubling the  
8 amount of time I was actually -- spent in clinic and it also  
9 increased my time two hours. So what I went from, is I went  
10 from seeing patients five hours a day to seeing patients  
11 three-and-a-half hours a day -- days a week and instead of  
12 getting home at 3:00 in the afternoon, where I could pick my  
13 kids up, I was getting home at 5:00.

14           My patients were very unhappy. I was very unhappy and so  
15 I actually went back to written records, so I could actually  
16 see my patients and take more time with them and then we just  
17 scan our records into the computer and have them on a PDF  
18 file. So I do have kind of an electronic health record, but  
19 at this point in time, because I do manipulation, it's very  
20 difficult for me to take the time to be able to document  
21 exactly what I do. It takes far too much time and far too  
22 many words.

23           One of the things that came up this week, alone, is like  
24 the DEA just set out a bunch of new rules and regulations on  
25 prescription coverage for controlled substances. So now,

1 today, I got a patient that was very upset with me because she  
2 had to come back into the office. I had to handwrite her  
3 address on there. I had to handwrite the diagnosis. I had to  
4 handwrite the diagnostic code and because I had put -- I'd put  
5 that the medication caused addiction on it, but I had put it  
6 in the wrong place. According to the new rules, it had to be  
7 below my signature. I had to rewrite the whole thing.

8 So there's so many new rules and regulations coming out.  
9 Each agency is different and it's very difficult for us to  
10 comply with all of these things. Plus, again, these  
11 preauthorizations are taking a lot of time because of all the  
12 paperwork and again, everybody's paperwork is totally  
13 different.

14 You know, the -- let's see, what else did I want to say?  
15 Prevention is actually the key here and one of the  
16 frustrations that I have as a primary care physician is I know  
17 my patient population. For instance, I have 68 women with  
18 breast cancer in my practice, which is a lot for a primary  
19 care physician and so I took a look at those and 50% of them  
20 are under the age of 50, and you know, nationwide, breast  
21 cancer strikes women at older ages.

22 Well, here in Alaska, at least in my practice, it's  
23 younger ages. So I'm going to want to order mammograms at  
24 younger ages than maybe other populations in the rest of the  
25 United States, but yet, the government is coming out with

1 these rules and regulations or in some cases, insurance  
2 companies, that say, "We don't think mammograms should be done  
3 under the age of 50."

4 So I'm kind of stuck between a government agency telling  
5 me what to do and what I see in my own practice and I see  
6 Alaskans and it's like who, you know, where do I go? Who do I  
7 listen to? Do I not do a test and get sued or do I do a test  
8 and get fined by the federal government or penalized by an  
9 insurance company because I've ordered a test and like I said,  
10 as physicians, our major job is taking care of patients and  
11 like J.C. was saying this morning on the phone, you know, a  
12 lot of physicians are getting fed up because they go overseas,  
13 they can actually practice medicine.

14 They can see 30 or 40 patients a day, because there's not  
15 documentation and they can actually do what they were trained  
16 to do as a physician. In this country, I've gone from seeing  
17 22 patients a day down to 12 patients a day and with all of  
18 these new rules and regulations, quality reporting measures,  
19 it's going to further reduce my cost (sic) and then with  
20 Medicaid reimburses me at about 80% of cost. Medicare was  
21 34%, but you know, the problem is that you cost shift then to  
22 the insurance companies in order to make your overhead and all  
23 these different things that are coming out are going to  
24 increase my overhead and take my time away from my patients.

25 So I ask you guys when you're considering these different

1 things, let me, as a physician, take time and spend time with  
2 my patient, because that is absolutely the most important  
3 thing and the most beneficial thing, because if I talk to  
4 them, it can help me to determine what medicines they need,  
5 what X-rays they do and -- may or may not need and if I am  
6 given two minutes with a patient, I'm more likely to order  
7 more X-rays and more labs because it will give me more  
8 information.

9 If you can give me 10 minutes with a patient or 15, I  
10 actually schedule 30 minutes with each of my patients, I can  
11 actually reduce the cost of medicine very considerably by just  
12 taking the time to be able to talk to my patient, get family  
13 history and get more information from them.

14 COMMISSIONER MORGAN: I just heard the end and I liked  
15 it.

16 CHAIR HURLBURT: Yes, David.

17 COMMISSIONER MORGAN: Thank you. I've known you many  
18 years, not that many years, but a long time. I guess I could  
19 give us all the good news or the bad news. I would give you  
20 the good news, but there isn't any. There's 12,000 regs  
21 coming. I've seen a lot of.....

22 DR. FARR: Twenty thousand pages.

23 COMMISSIONER MORGAN: Well, 12,000 new ones and I think  
24 you summed it up in the crux that we have a tsunami of cost  
25 that's going to be rippling through that's not been scored

1 because you can't score a cost until it's been -- the reg's  
2 been promulgated and therein lies the paradox.

3 We passed the -- we, as a country, passed a law at about  
4 830, the secretary shall, and we're about halfway and right  
5 now if you pile the regs up, I have a picture of it. They're  
6 -- it's six-and-a-half feet of -- if you pile the paper up.

7 So I don't know what to tell you, other than we're  
8 swimming in a lake of paper, of regs and all this is going to  
9 add cost and I know I've got a bulletin here that, not the  
10 group rates, but the individual insurance rates in California,  
11 just like for a family, this year's going to go up about 88%.

12 It's -- Jeff's been warning us, between the minimum  
13 requirements for the plans and the tax and the subsidies that  
14 are being hit, it's going to be phenomenal or almost biblical,  
15 I think of what's coming and having a small population state,  
16 we don't have any way, really, to spread that -- from that,  
17 but Jeff Davis has been warning us for, what, two years what's  
18 coming and we all rolled our eyes, but guess what? It's  
19 starting to happen in other states.

20 So I -- and I'm truly sorry that you had such a hard time  
21 getting in, because I was talking to your nephew and I saw the  
22 phone calls and I know you were trying. We just have been  
23 having some technology problems, I think. These things  
24 happen, but we will always make time to hear from an  
25 individual, a consumer, a physician or anybody that wants to

1 talk to the Commission. Nobody said we don't want to hear  
2 from you, as far as I know. Right, guys?

3 DR. FARR: I know there's a lot of physicians that would  
4 have liked to had input and when these Commission hearings are  
5 during the day, they cannot come in. I mean, I make special  
6 time to try and do it, but I know -- I wish there was some  
7 evening that you guys would have where you'd come and just  
8 have providers come and get their input because we are the  
9 ones that are, you know, at the base that are actually  
10 providing the care to patients and I'm really concerned about  
11 this Medicaid expansion that is proposed.

12 It's going to increase my taxes. It's going to decrease  
13 my reimbursement, if I can do Medicaid patients and it's going  
14 to result in cost shifting on the part of a lot of physicians  
15 and it's going to result in decreased access to primary care  
16 providers by Medicaid and Medicare patients.

17 So I have questions about that and I also had a question  
18 -- I mean, a comment from another physician that just did that  
19 CMS requirements on the EMR for quality performance. I can't  
20 remember what she called it, but anyway, it was a quality  
21 reporting thing and what she said was that Medicare had  
22 basically made a promise to them that they would get a 2%  
23 increase reimbursement if they did all of this stuff.

24 Well, then the sequester happened and they got decreased  
25 and she said that it cost her probably \$120,000 to set up the

1 electronic health system and get it so it was compliant with  
2 all of the things. She got \$44 worth of reimbursement and  
3 she's thinking about dropping it because it is costing them so  
4 much extra money.

5 So again, it may sound like a good idea, but the  
6 practical application of this, and this is someone that is  
7 really knowledgeable about computers, unlike me. So I just  
8 want to let you know there are unintended consequences and  
9 what I'm really afraid this bill is going to do is actually  
10 drive insurance companies out of business because the premiums  
11 are going to be so high, people are not going to be able to  
12 afford them and I could spend an hour talking about it, but  
13 spouses were not covered under the ObamaCare and I am seeing  
14 employers drop spouses at this point in time and the spouses  
15 have to go back to work, but -- and there's lots of other  
16 things that I could say, but I think I'll stop there.

17 CHAIR HURLBURT: Yeah (affirmative), thank you. I think,  
18 you know, we have seen -- Aetna has pulled out of the  
19 individual market in California for the reasons that you  
20 mentioned. We've seen that kind of thing happen in other  
21 states, the individual market was destroyed for a while in  
22 Washington state when they imposed some of those.

23 As far as the Medicaid expansion, Alaska has decided that  
24 we will not provide the Health Care Exchange and the feds will  
25 come in and do that. I guess for better or for worse. We'll

1 see what it does, but as far as Medicaid, the Governor has  
2 stated that he will make his decision at about the time, or  
3 make it public, and he hasn't made it yet, but about the time  
4 the budget is presented, which will be mid-December.

5 In the meantime, the department continues to work on  
6 that, but a -- Alaska has not made a decision to participate  
7 in the Medicaid expansion and so that's still a question  
8 that's up in the air and individuals -- there's certainly many  
9 individuals who think it's a good thing and will -- to provide  
10 and meet some unmet needs and I know they're making their bias  
11 known and I think others who have concerns have the same  
12 opportunity.

13 DR. FARR: I wish they would let us, as physicians, just  
14 write-off the losses that we have from these uninsured  
15 patients, instead of making it fraudulent for us to discount  
16 them below what we charge other patients.

17 I mean, it's the government that's interfering with a lot  
18 of the charity care that we, as physicians, used to provide  
19 and that's actually one of the reasons why I opted out and 10%  
20 of my practice is now charity care to try to help the  
21 uninsured, unemployed and people that are going through hard  
22 times and my Medicaid patients or Medicare, I charge them all  
23 the same because I don't want to commit fraud, but we take  
24 whatever they can afford to pay, but there's probably a lot  
25 more physicians that are going to end up going to this model

1 in the future, but I was just talking to a patient yesterday,  
2 they cannot -- nobody can get an individual Ob policy here in  
3 the state of Alaska.

4 So my patients that do not have insurance now are having  
5 to save about \$10,000 to be able -- before they can have a  
6 child and so, you know, there's some definite issues that need  
7 to be addressed up here by all of us and I think we have much  
8 better solutions up here in Alaska than some of them that have  
9 been proposed, but I think the primary care providers really  
10 need to get involved in that discussion.

11 CHAIR HURLBURT: Thank you and thank you for your  
12 persistence.

13 DR. FARR: Thank you. I was yelling at both the webinar  
14 and the phone and my cell phone. I'm trying to get through.  
15 It's like, I am here. Thank you.

16 CHAIR HURLBURT: Okay. We'll go on. The next -- we want  
17 to talk about the draft findings and recommendations on  
18 improving Alaska's health information infrastructure and  
19 transparency and Deb is going to lead that part for us.

20 MS. ERICKSON: I need to take over the screen. Do I have  
21 it now?

22 UNIDENTIFIED VOICE: You've got it.

23 MS. ERICKSON: I've got it, okay.

24 UNIDENTIFIED VOICE: (Indiscernible - too far from  
25 microphone).

1 MS. ERICKSON: Very good, okay. Well, before we talk  
2 about -- what we're going to do this afternoon is spend a  
3 little time brainstorming our findings and recommendations  
4 related to transparency in general, state laws, mandating  
5 providers to report as an option, all-payer claims database  
6 and hospital discharge database.

7 If you want to -- after the serious information overload  
8 and issue overload today, if you want to just spend some time  
9 sharing some general thoughts that aren't related to any of  
10 those specific strategies, that might be a good idea.

11 I did want to provide some little clarification, because  
12 when we started bleeding over during the discussions about the  
13 hospital discharge database and blending that conversation  
14 with the all-payer claims database and as -- I think we got a  
15 little bit confused in that conversation and I just wanted to  
16 remind folks about, at least a couple, there are probably  
17 others, but these are the two main points I could pull out of  
18 my head; the hospital discharge database was never something -  
19 - and now, it's become potentially a broader service reporting  
20 database -- was never a database that we talked about in terms  
21 of supporting transparency for price information for  
22 consumers.

23 Perhaps for some levels of quality, but other management  
24 and public health uses is what we had addressed and we're  
25 concerned about the gaps in this database right now. We're

1 having to deal with those.

2 The hospital discharge databases provide charge data.  
3 They don't provide reimbursed, paid reimbursements. So it's  
4 not something that would give us very rich information on paid  
5 claims. An all-payer claims database, the payers report to  
6 it, not the providers and one of the things when we were  
7 initially studying all-payer claims databases, one of the  
8 benefits that was identified of an all-payer claims database  
9 was that there's no burden imposed on providers because  
10 they're not having to submit the data, that it's coming from a  
11 relatively small handful of payers and there is paid claims  
12 data and one use of the data, as we saw, was for transparency.

13 So I just wanted to make -- go -- take a minute to step  
14 back and provide some clarification on the differences between  
15 those two databases and I don't know if I missed anything  
16 important about the differences. Yes, Dr. Urata and then Dr.  
17 Harrell.

18 COMMISSIONER URATA: So according to Jeff or Mr. Davis,  
19 Jeff's good, okay, it would -- the all-payer claims database  
20 in Alaska would be just a small segment of claims. Is that  
21 correct, or will it also include the self-insured, et cetera,  
22 et cetera, and would it provide enough data for us to be  
23 useful?

24 COMMISSIONER DAVIS: So do you remember Roseanne  
25 Roseannadanna, Saturday Night Live, yeah (affirmative), you

1 know, they go through a big long spiel and then be corrected  
2 and say, "Never mind." Well, that was my Roseanne  
3 Roseannadanna moment where I went through all of that and then  
4 turned and Deb corrected me that no, in fact, other states  
5 have gotten Medicare and have been able to, and which it  
6 surprises me, compelled the self-funded to also do it. So I  
7 withdraw that limitation. If it's a -- it has to be a  
8 statutory change to state law. So it would require that. So  
9 sorry for the confusion.

10 CHAIR HURLBURT: And in the Monday meeting of the House  
11 Finance subcommittee for HSS, several of the members of the  
12 House that were there are very concerned about health care  
13 costs and were open, were asking is this something we should  
14 do? Should we have legislation?

15 Now, they don't speak on behalf of the total Legislature,  
16 but it wasn't just a closed wall -- that it wasn't something  
17 that they would be willing to consider if having an all-payer  
18 claims database got us to the point where there was more  
19 transparency and we had more enlightened purchasing of health  
20 care with price and quality information.

21 If there were, right now, that last part is a big  
22 question mark in my mind, but it would take a law and with the  
23 other states, as Deb said, they have been able to include the  
24 employers who are able to be exempt from some of the other  
25 restrictions that health plans by operating an ERISA plan, but

1 they have been able to include them.

2 I think that the federal sector or the Tribes operating  
3 kind of in lieu of the feds, that would be a question. Some  
4 have said, "Well, I think they'd be willing to participate,"  
5 but if you had a state law that said the Tribal Health System  
6 had to participate, I think the Tribes could say, "No, under  
7 sovereignty, we don't have to," and the same with the federal  
8 government, that they might be willing to do it and Medicare,  
9 CMS is beginning to provide more of that information.

10 They've done it with hospitals. They've delayed it for  
11 physicians by about six months, but they say they're going to  
12 do it for physicians, also for Medicare enrollees. So I think  
13 that if it was something we felt was worth doing, there's a  
14 chance the Legislature would understand that and support it.  
15 It's a possibility and that we could get the vast majority of  
16 payers and maybe virtually all, if we could make a case to the  
17 Tribal Health System and to the feds to do it. Yeah  
18 (affirmative).

19 COMMISSIONER URATA: A follow-up, so if we do all-claims  
20 payer -- then would we need to have a discharge database?  
21 Would it replace it so that would release the burden of  
22 hospitals doing that?

23 CHAIR HURLBURT: I think the data comes from different  
24 places, but there's a cost of doing either one -- to doing --  
25 to either expanding the hospital discharge database and making

1 sure it's turned more into information, as Karen was talking  
2 about, instead of just data that's not used a lot or Pat said,  
3 "I don't even look at it, you know, it's not worth my time,"  
4 that to try to make it into real information, there would be  
5 some cost.

6 There would likewise be some cost for an all-payer claims  
7 database and at a time where we have to look at budget cuts,  
8 this is asking us to do something new. I think if we've got  
9 one, that would be fairly impressive. So I think  
10 realistically that at the present time, anyway, we would need  
11 to talk about one or the other. That's my personal opinion.  
12 Yeah (affirmative), Keith.

13 COMMISSIONER CAMPBELL: That question is answered under -  
14 - on the Health Care Commission draft summary report. It says  
15 it is a supplement to the hospital discharge base or hospital  
16 discharge base is a supplement to the.....

17 MS. ERICKSON: Right, they've been described as  
18 complimentary. There probably is a lot of information that is  
19 available through hospital discharge database that would be  
20 available through an all-payer claims database.

21 The one big gap would be the uncompensated care or self-  
22 pay. So those two data sources are missing from an all-payer  
23 claims database or types of data are missing from the all-  
24 payer claims database.

25 COMMISSIONER HARRELL: Deb, I wanted to clarify one more

1 time for you, because I'm coming at this from a provider  
2 perspective and a little bit of a knowledge gap. You  
3 commented, "Hey, the big difference between the APCD and the  
4 discharge database is, hey, it's a payer reported issue," but  
5 to get to that payer report, you're still going to impose and  
6 administrative burden on a provider. They have -- their  
7 coding and everything else has to flow into that, does it not?

8 CHAIR HURLBURT: No. No, it comes from payers. It  
9 doesn't involve the providers and the information that you  
10 would get is the information that I'm sure Jeff uses. It's  
11 the information that I used when we had 330,000 Medicaid  
12 enrollees in our plan in Washington state. I had all that  
13 information and we used it to look at it to see what's the  
14 quality, to look at what it was costing us.

15 What are our alternatives? Do we want to drive some  
16 steerage to one place or another, either for quality of cost  
17 reasons? So it's not new data. If you have enough lives, you  
18 have it already. The state gets some of that for the active  
19 employees and retirees and dependents from the TPA that's  
20 doing that and there probably could be more.

21 So with enough lives, you're getting that already. This  
22 would make it available to everybody. It would be more  
23 transparency and the individual, if they wanted to use it,  
24 could use it productively, but so far, that hasn't happened  
25 around the country.

1           COMMISSIONER DAVIS: May I take a run at clarification,  
2 as well? So the key word is claims. So providers today  
3 submit claims to us to get paid and this would be simply  
4 reporting back, requiring all payers to report back that  
5 claims data.

6           So it's not any new burden on the provider. They're  
7 submitting claims today for reimbursement. It's just an  
8 additional reporting requirement on the payers to put it back  
9 into a central repository. It has its limitations, but it's  
10 way more than we have now.

11           If I may, Mr. Chairman, so I thought -- I felt like I'm  
12 of three minds of this particular subject.

13           MS. ERICKSON: The last meeting, it was only two minds.

14           COMMISSIONER DAVIS: I know, well, let's have a couple  
15 more and I'll be of five minds on it. Tomorrow, I have the  
16 privilege of presenting to you about health insurance and  
17 you'll see at least two times that I might be saying that  
18 price transparency is an important part of driving waste out  
19 of the system, at least twice and maybe three times, and I  
20 can't recall for sure.

21           So where I'm struggling is if I thought all -- and my  
22 policy people are probably on the phone and ready to strangle  
23 me if they could, but you know, if I really -- if I was sure  
24 that there was a direct tie between an APCD and the ability to  
25 provide meaningful cost and quality transparency, I would be

1 of one mind, but I'm just not quite convinced yet.

2 Maybe there is no other path, but that's where I'm really  
3 struggling with this and I would -- I don't want to see us  
4 taking a leap of faith that takes us down a road that years  
5 from now has consumed a lot of resources, but not accomplished  
6 what we set out to do.

7 So maybe it's knowing more about specifically what New  
8 Hampshire and Maine are doing with that or what Colorado's  
9 thinking about doing with and seeing that direct link, and if  
10 we could, maybe we could see our way.

11 The last comment I'll make, if I could, is looking at  
12 Karen Purdue's handout, maybe there's a middle way here, she  
13 talks about in the last couple of paragraphs, the need to have  
14 a process. Before we get to any answer, we need to have a  
15 process that involves all the stakeholders and around the  
16 table, but I think in a more robust and focused fashion and  
17 Dr. Delbanco also talked about needing to have the end in mind  
18 before you start down the journey.

19 So you know, perhaps in the end, our recommendation is  
20 not yes or no, but our recommendation is further study is  
21 required and following an outline or a format somewhat as  
22 Karen has proposed to us today. Thank you.

23 CHAIR HURLBURT: Yeah (affirmative), I think, you know,  
24 that she was describing (indiscernible - voice lowered) in  
25 your collaboration among your three minds where you end up.

1 That's where I am and it's not where I want to be. I really  
2 thought that this was going to help, but I don't think from --  
3 at least at this point, from what I've heard, that I'm  
4 convinced enough that I would say with confidence to the state  
5 that we need to do this. Yeah (affirmative), Pat.

6 COMMISSIONER BRANCO: Likewise, I'm divided on at least  
7 three planes, as well. I'll start with the simple one, my  
8 hospital -- this is a private industry. This is a business.  
9 There are business interests. There are competitive market  
10 forces even in Ketchikan and so it's a little antithetical to  
11 think public-mindedly and say spring it all open, expose --  
12 for the good of a community, a state and the population of the  
13 country, it's the right thing to do to begin to do this, but  
14 it does push against that other side of my brain that says be  
15 very conservative on how much you open up.

16 So I want to do a moment on transparency and it does go  
17 back -- I referenced -- Ken is a good guide to me and one of  
18 the key points, he did it fast and it was subtle, is the  
19 patient needs to know what question to ask to really get --  
20 you may get that price that says it's \$1,020 for a  
21 colonoscopy. Did you really get the answer. Was that  
22 transparent enough and it's going to be this fundamental shift  
23 in how we, as consumers of health care, really begin to take  
24 control back on how we manage our care and become much more  
25 involved and much wiser.

1           So Emily and I did a very quick whispered comment at one  
2 break and it said, "How do we help our patients get smarter  
3 about asking those questions?" We can give them the  
4 transparency. It doesn't mean they'll know how to use it  
5 well.

6           CHAIR HURLBURT: Yeah (affirmative), and what's -- and  
7 then what's challenging to the patient and it's something  
8 that's been written about nationally now, but you need a  
9 fairly sophisticated buyer to be able to push back on you and  
10 say, "Why do you need that thousand and some dollars for an  
11 anesthesiologist," and to reasonably contend you do not need  
12 an anesthesiologist to do a colonoscopy or a nurse  
13 anesthetist, and you know, it's an issue of argument in the  
14 country, but that's a part of a fair negotiation of putting  
15 pressure on you as a provider and you say, "Well, how am I  
16 going to pay for them," and you know, that's a part of it, but  
17 that's got to be the negotiating process.

18           COMMISSIONER BRANCO: I think Liz Woodyard nailed it if  
19 she -- oh, she's gone, sorry. Good, than I can attribute it  
20 to her and she won't take the blame. She likened it to going  
21 to a restaurant. Very quickly, I love analogies, going to a  
22 restaurant, walking in the door and saying, "I'd like  
23 chicken," and the answer is, "Well, great, but I want to pay -  
24 - I know it's \$3.00 a pound. I want to pay you \$3.00 for the  
25 chicken." Well, this restaurant, you can go to McDonald's and

1 you can have a really nice chicken sandwich and it will cost  
2 you \$4.50 or you can go to this restaurant and it will cost  
3 you \$44.00 because the executive chef -- there is transparency  
4 in pricing. There are consumer expectations and demands,  
5 choices and quality and so, yes, your point is well taken, but  
6 it is more complex the more we begin to look at it and an  
7 informed consumer will become much more engaged in saying,  
8 "Today, I want the 44-dollar chicken meal delivered to me on a  
9 gold plate."

10 COMMISSIONER URATA: I'm undecided, too, and thinking  
11 that we should probably hold off and -- because while I agree  
12 that we need transparency, I'm not sure that this is the right  
13 way of doing it and it might be wise to wait and see what  
14 happens to the two previous experiments that are going on  
15 right now to see if it really pans out and does what we want,  
16 but on the other hand, on the discharge database information,  
17 I think we may need to level the playing field by considering  
18 a recommendation to have other people submit data that  
19 currently are not submitting data, but are taking advantage of  
20 their status, you know, like the surgery centers and the  
21 imaging centers, who, in some people's opinions, take the crop  
22 or cherry-pick the paying patients away from the hospitals and  
23 here, the hospitals are kind of required to do extra work with  
24 their data, so.....

25 MS. ERICKSON: Can I step in and be an active facilitator

1 for a second?

2 CHAIR HURLBURT: (Indiscernible - too far from  
3 microphone).

4 MS. ERICKSON: But usually, if we have a -- I know, I'm  
5 not doing my job. Well, usually, we have one specific focused  
6 question and I'd prefer to just allow you all to talk and  
7 capture your thoughts, but we really have three with multiple  
8 other questions imbedded in those, but since we're back on  
9 hospital discharge database and as we revisited it a few  
10 minutes ago, hospital discharge database really isn't about  
11 the transparency question as much, while we -- one of the uses  
12 is for some level of quality transparency, understanding you  
13 don't get the rich clinical data from an administrative  
14 database like this, but there could be some measures of  
15 quality drawn from this.

16 Other uses, we're studying utilization and public health  
17 uses and I've detailed some in our policy analysis that you  
18 have in your notebooks that you all read before you came,  
19 twice. So the question is -- we have a recommendation on the  
20 books right now from two years ago that the department look at  
21 ways to strengthen and engage the hospitals that weren't  
22 participating and participating.

23 ASHNHA was really actively involved in getting some of  
24 the smaller hospitals that had not been participating in the  
25 past onboard and participating on that, but as we've just

1 heard now, Providence is dropping out and I think we still  
2 don't have -- haven't all along had the smaller Tribal  
3 facilities participating.

4 We've had the suggestions from the -- two hospital  
5 administrators from the largest hospitals in our state that  
6 aren't now, as of today, participating in the hospital  
7 discharge database.

8 So the question is; do we want to leave the current,  
9 little bit soft general recommendation that the department  
10 should encourage full participation and just leave it at that  
11 and ask Commissioner Streur to come report to us periodically  
12 on how he's doing with that or do you want to get more  
13 specific in that recommendation?

14 Do you want to recommend that there be a mandate, either  
15 in state law or regulation? I included a copy of a section of  
16 our state law that I think actually already states hospital  
17 discharge database as an opportunity for public health  
18 information and it's possible that we would not need  
19 legislation, that the department could promulgate regulations  
20 under existing statutory authority.

21 Regardless, I guess the question is; do you want to  
22 strengthen this so that it would state that there should be a  
23 legal mandate to report, and if so, are there certain  
24 principles, like the ones that were suggested by Dr. Mandsager  
25 and Mr. Lee and others that have come up around the table that

1 you would want to include? Yes, Jim.

2 COMMISSIONER PUCKETT: Being a new Commission member, is  
3 there a time restraint we have? Do we have to have a  
4 recommendation written this meeting or can it wait until maybe  
5 another meeting?

6 MS. ERICKSON: At other meetings, we might have time to  
7 revisit and refine, but we really aren't going to have time to  
8 go back and spend time on the information infrastructure  
9 components that we're discussing today.

10 CHAIR HURLBURT: One of the requests that we had on  
11 Monday from the House Finance Subcommittee, where they were  
12 really very much looking to the Health Care Commission for  
13 support and help and advice, was if we have to wait until  
14 January 14th, which is by the legislation when our  
15 recommendation is due, they say by then, we are just so up to  
16 our ears in everything, it's hard to deal with, and so part of  
17 my response to them was, "Well, we do, and usually by October,  
18 late October sometime, are ready to go out for public  
19 comment," and you know, they -- the recommendations can be  
20 changed, but that's pretty much what they are and they said,  
21 "You know, we'd like to have it by August," but they are  
22 taking our recommendations seriously, but said, "You will help  
23 us if we can get it sooner." So I think that it sounded like  
24 it would be profitable to them, but we can't wait too long to  
25 do it.

1           COMMISSIONER PUCKETT: No, I can understand that they're  
2 demonstrating an interest that they've not demonstrated  
3 before. I -- even experienced that in the last session. My  
4 division was very, very, very busy. The busiest I've seen it  
5 in five years with handling information requests and  
6 legislative inquiries about health care, particularly our  
7 health plan, but it was clear they're animated and they are  
8 educated now.

9           I was just wondering if we could have enough time to  
10 investigate the difference in the expense of expanding the  
11 discharge database, what that would cost, as compared to the  
12 cost of implementing an APCD? Do we have time to do that or -  
13 - because I don't think we've really looked at that part of  
14 it, at least I have not.

15          COMMISSIONER CAMPBELL: I'd like to ask Senator a  
16 question. What is the general feeling in the Legislature  
17 about mandates such as this that we're tip-toeing up to?

18          COMMISSIONER COGHILL: Well, there's 60 people there and  
19 you're going to have a lively debate, just like you had a  
20 discussion here. I think, though, you'll find a reluctance to  
21 do a mandate, unless there is a real deliverable from it and  
22 so what I've heard today is it's -- there's still an open  
23 question on the deliverable.

24          You're going to hear the docs come in and say what you've  
25 heard here, that you're putting a burden on -- I mean, no

1 matter how it shakes down, it's going to be a burden on us,  
2 because even if the payer is the one that has to do the  
3 reporting, it's all going to flow down to the doc. So if  
4 their existing reporting requirements, that's fine. So on the  
5 -- doing the larger (indiscernible - voice lowered).

6 Now on this part with the hospitals, I think your -- the  
7 database that I've heard here is -- it's still a question on  
8 some usability. There are going to be some questions that  
9 came to my mind, I know that people are going to ask. For  
10 example, in my neck of the woods, I've got a huge population  
11 of retired military people. What's the effect and what is the  
12 drama going to be there? I don't know what that would be. So  
13 that would be one of the first questions we'd ask.

14 So I don't know if it's (indiscernible - voice lowered)  
15 or what the medical pay is, but hospitals there are going to  
16 have a different response than you would from a third-party  
17 payer or from the Indian Health Service.

18 So I don't know if that is going to be very helpful to me  
19 as a legislator. So I'm going to look at a mandate reticently  
20 before I'm willing to get some benefit. Now the benefit we'll  
21 be looking for is how do you get, just like you're asking, the  
22 best quality at the lowest cost?

23 You know, so some of the questions that have arisen in my  
24 mind here, as you -- as I've listened to the debate, is in  
25 transparency, you're trying to get the consumer and the payer

1 to agree on what is the best value for that consumer and the  
2 hospitals want to deliver it. The docs want to deliver it.  
3 The third-party payers are responsible for delivering it, but  
4 they get to make decisions that the consumer doesn't get to  
5 make and so in the hospitals, it -- this is just me, it looks  
6 like the hospitals have more of an allegiance to the payer  
7 than to the consumer and that's not what I've heard here  
8 today, as far as what we want to deliver, but when it comes to  
9 the dollar, the allegiance is going to follow the dollar.

10 So in my mind, before I would be willing to put a mandate  
11 out, I want to know is there any way of getting a better  
12 connection between the consumer and the payer when it comes to  
13 those choices? It's just -- and if you have the military  
14 plan, you have the ERISA plans, you have TPAs, you have  
15 individual insurance plans, they don't correlate real well and  
16 so a mandate falls on a narrow band, it looks to me like --  
17 and before I'd be willing to put a mandate, I want to know  
18 what we get from that and I haven't heard anything that helps  
19 me understand that better yet, today. Does that sound very  
20 confusing?

21 COMMISSIONER CAMPBELL: Well, I think I was talking from  
22 the mandate of expanding so that the hospital that was out and  
23 the hospital that's going out, still stays here and.....

24 COMMISSIONER COGHILL: I see. Well, I can address that a  
25 little bit.

1           COMMISSIONER CAMPBELL:   .....in that system and then  
2 expanding that.

3           COMMISSIONER COGHILL:   Right, that's.....

4           COMMISSIONER CAMPBELL:   That's basically where I was  
5 headed with the question.

6           COMMISSIONER COGHILL:   Well, the deliverable is still the  
7 question and so the -- so I'm going to hear from the larger  
8 hospitals a desire that if they're going to enter into this  
9 competitive world, they want everybody in it and the problem  
10 with that is they are huge gorillas in the health care  
11 delivery world in Alaska and so there's going to be a real  
12 reluctance to, and this is just my view, a real reluctance to  
13 have them force a mandate on people who have less apparatus to  
14 compete with.

15           So I just think there's going to be a real reluctance  
16 there. That's from my perspective and admittedly, I'm a  
17 novice here, yeah (affirmative).

18           COMMISSIONER URATA:   You know, the current way it works  
19 is voluntary and it's up to ASHNHA as the agent that tries to  
20 accomplish this. Maybe it should be thrown back to ASHNHA and  
21 let them try to work it out.

22           MS. ERICKSON:   I think that's what we've been doing for  
23 the past couple of years and I think that's why we heard what  
24 -- I think one of the things that we head today was that one  
25 of the challenges, from our two hospital CEOs, that one of the

1 reasons they're not participating is because there are other  
2 similar facilities that wouldn't be a part of ASHNHA that  
3 aren't hospitals that are not participating and that they  
4 don't feel that's fair.

5 So I thought what I heard them both say is that they  
6 would accept a mandate and that they would report under a  
7 mandate if it was fair in their perspective and it wasn't just  
8 hospital facilities being required to participate and they  
9 named the other types of facilities that they thought should  
10 be included and that it -- and that the requirements be  
11 consistent and consolidated to the extent possible, if they  
12 had other reporting requirements.

13 COMMISSIONER URATA: So if we don't get information and  
14 this thing falls apart, what do we lose?

15 MS. ERICKSON: The data, and it's unfortunate -- one of  
16 the things that Karen mentioned was a suggestion that IBIS,  
17 which is a public health database that's going to be -- it's  
18 supposed to go live a little bit later this summer, the public  
19 health folks are taking 10 years' worth of hospital discharge  
20 data and putting it into this system and we'll be able to see  
21 it in another month or two, I hope.

22 So I think it'll give us more of a hands-on ability to  
23 look at the public health uses for it. I couldn't speak with  
24 any specificity to how the department uses that data for  
25 studying utilization. I understand, although to hear from

1 Pat, he doesn't really look at it, but then, he doesn't have  
2 any market competition directly in his community, anyway, that  
3 there are hospitals that do use the data for doing market  
4 analysis and planning.

5 There are -- the nonprofit hospitals have a new  
6 requirement under the tax laws that every three years, they  
7 conduct a community needs assessment and that they develop a  
8 strategic plan for how they use their community benefit  
9 dollars and do future planning based on the community needs  
10 assessment. This is a source of data that I think would be  
11 important.

12 In terms of the public health uses of the data, we have  
13 lots of data and public health about mortality from death  
14 records, what people are dying from, but this is once source  
15 of data that provides information on morbidity in the  
16 population, at least to the extent it's requiring some sort of  
17 hospital usage right now, short of surveys, where it's self-  
18 reported like the behavioral risk factor surveillance survey.

19 So that's -- and I did have somebody -- so we had Marge  
20 from the Lung Association talking about how both data sources  
21 are important for them to do planning and to support disease  
22 management activities around asthma, as one example.

23 I heard recently, and this was probably a huge mistake,  
24 I'll just say it and even if I offend the people who made the  
25 decision, that folks responsible for the trauma registry

1 decided to discontinue reporting adult poisoning and so the  
2 folks who are responsible for -- yeah (affirmative), somebody  
3 sat up straight. So now the folks responsible for studying  
4 suicide and suicide attempts have just lost that data source  
5 and came to me very concerned that the hospital discharge data  
6 is not quite as rich as the trauma registry data, but it's  
7 going to be their only source for that data now, but if the  
8 hospital discharge database falls apart with Providence  
9 pulling out, that they've lost that sort of data for studying  
10 suicide attempts in the population.

11 So that's examples of some public health, which I'm a  
12 little more familiar with. I don't know as much about how  
13 individual hospitals might use them for market analysis and  
14 how the department uses it for studying utilization for  
15 various policy questions related to Medicaid and probably more  
16 likely certificate of need. Yes.

17 COMMISSIONER URATA: Could the all-payer claims database  
18 replace it? That's -- this is the second time I've asked that  
19 question.

20 MS. ERICKSON: I think, you know what -- yeah  
21 (affirmative), one -- I don't -- I don't think that they  
22 should be considered as one or the other, while that seems  
23 like it would be a simpler tradeoff, one of the benefits -- we  
24 mentioned earlier that what we would lose with an all-payer  
25 claims database instead of having a hospital discharge

1 database is information on self-paid services and on  
2 uncompensated care. So we would lose that if we did just an  
3 all-payer claims database.

4 I think one of the things, just as thinking from an  
5 operational administrative perspective, if we were to go to  
6 one or the other, one of the things I would want to consider  
7 as -- with a state policy hat on, is we have a functioning  
8 hospital discharge database and Karen said earlier, it's not  
9 broken and it's not broken (sic). The database isn't broken  
10 and just what's wrong with the system right now is that enough  
11 of the participants in it feel that it's not fair the way it's  
12 being -- the way the system's structured. So they don't want  
13 to play anymore.

14 It makes more sense to me, and I hate to pull numbers off  
15 the top of my head, Jim, but we do have information, I  
16 included it in your packet a cost study and I'm not  
17 distributing it and I'm not putting it on the web because it  
18 is proprietary for members only of the National Association of  
19 Health Data Organizations, which we're a member of.

20 You didn't know that, did you, but there is a report on  
21 the -- that is an analysis of the costs of running the  
22 existing all-payer claims databases and it really is very much  
23 in line with the cost estimate that we got from the Freedman,  
24 which was about a million dollars and that includes  
25 everything, collection, maintenance, cleaning and all of the

1 analytics to run reports on the data and to analyze it. So  
2 about a million dollars a year, operations, I think kind of  
3 the top end, for annual maintenance for an all-payer claims  
4 database and startup costs were not that much, I think about  
5 half that, the one-time startup costs.

6 Hospital discharge database, Karen mentioned a figure,  
7 \$80,000. That's the department and that's what she was  
8 talking about how the department's scrounges this data  
9 together. The department pulls together about \$86,000 a year  
10 to provide in a grant to ASHNHA, which they, in turn, pass  
11 through to HIDI, which is the organization that is the data  
12 aggregator. It's the group that they pass the data through  
13 and they maintain it, clean it. So there's not a lot of money  
14 there.

15 The department's managed to scrounge it together. I do  
16 not know -- Karen didn't mention how much, and I'm sure  
17 there's plenty of money that ASHNHA's putting into supporting  
18 it, at least in kind and staff time, yeah (affirmative). The  
19 one thing she mentioned as a significant gap is any resources  
20 going into their -- and that's why we're struggling a little  
21 bit because we don't have anything real solid we can put our  
22 hands on, is the department has never invested in the  
23 analytics piece and so.....

24 CHAIR HURLBURT: Deb, the initial request, and it will be  
25 much lower, but if we go ahead with a request to expand the

1 hospital discharge database, it will include positions and the  
2 initial request came in comparable to the figure you just  
3 quoted for an all-payer claims database. It leaves \$80,000 in  
4 the dust.

5 So it's got to come in much lower than that if the  
6 request goes in, but there's, you know, the initial request is  
7 a whole lot of money.

8 MS. ERICKSON: Can I ask if that request was from  
9 Division of Public Health staff?

10 CHAIR HURLBURT: No, because we're not going to submit a  
11 request like that.

12 MS. ERICKSON: Well, no, I guess my question was.....

13 CHAIR HURLBURT: But yes, it did come from.....

14 MS. ERICKSON: Was it lower-level agency staff estimating  
15 it?

16 CHAIR HURLBURT: It did come from Public Health Division  
17 staff, yes.

18 MS. ERICKSON: Yeah (affirmative), I would like to see it  
19 and I think we could push back and challenge and come up with  
20 something more efficient and effective.

21 CHAIR HURLBURT: It's already been pushed, but that's  
22 what.....

23 MS. ERICKSON: Especially if it has lots of.....

24 CHAIR HURLBURT: .....the request was, yeah  
25 (affirmative).

1 MS. ERICKSON: .....lots of positions included, because I  
2 think one of the things that we -- I've learned, studying what  
3 other states are doing with all-payer claims database and  
4 hospital discharge database is vendors are getting more and  
5 more sophisticated in supporting the data owners with analytic  
6 packages that from the users perspective is kind of just a  
7 push and play type thing.

8 So I would not imagine that something that we would add  
9 state staff to build a capacity to do that type of work, that  
10 we would need to pay for it and it wouldn't be cheap and it  
11 would be way more than the \$80,000 probably, but I don't -- I  
12 think it would be well short of a million dollars, too.

13 CHAIR HURLBURT: It should be, but we may not -- it may  
14 not be totally apples and oranges in terms of cost. I don't  
15 think we should necessarily look at the discharge database  
16 expansion as being a bargain and the other as costing a whole  
17 lot and right now, I'm hearing, and Allen has a comment, and  
18 I'm interrupting that, but right now, I'm hearing questions  
19 about the utilization of either one, other than the public  
20 health things as you mentioned.

21 MS. ERICKSON: Well, we maybe should find out what the  
22 department's needs are related to the certificate of need  
23 program. That's a real important question and I think the  
24 public health uses are important. I don't understand why --  
25 and we should go back to our vision. I kept wanting to push

1 people back to our vision all day today, actually, and Keith  
2 could see that I was squirming and wondering if we were going  
3 to get ourselves in trouble here, but remember that while  
4 we've been really focused on cost and if we don't do  
5 something, it's going to be done to us.

6 The most significant part of our three-part vision is  
7 about the health of the population and health outcomes and if  
8 we have no way of measuring that, how are we going to know  
9 we're accomplishing anything in terms of improving the health  
10 of the population, and supporting informed policy decisions  
11 about public health.

12 COMMISSIONER HIPPLER: Thank you. My thought is that I  
13 would oppose a mandate to have all hospitals provide the  
14 discharge information and I would strenuously oppose extending  
15 that to these surgical centers.

16 I understand -- I totally sympathize with the hospitals  
17 that it is unfair that they are burdened with this massive  
18 regulation and the surgical centers are not. I get that's not  
19 fair, but the solution to huge overwhelming regulation is not  
20 making sure that everybody suffers the same regulation, it's  
21 trying to reduce the regulatory burden and the way to level  
22 the playing field is to reduce regulatory burden, not increase  
23 it for everyone.

24 So I have to throw that out there. I don't want the  
25 surgical centers exposed to that and as for the mandates on

1 the discharge, I do think that it, even though hospitals can  
2 absorb a lot of that cost because they have the overhead  
3 already to deal with it, if they don't want to do it, I'm very  
4 reluctant to force them to do it and as was pointed out  
5 several times, there has to be a really big carrot. There has  
6 to be a reason why we would force this mandate through that's  
7 to the benefit of the people to push this through. So at this  
8 time, I would oppose it.

9 COMMISSIONER COGHILL: Just to speak to the mandate  
10 again, point well taken on certificate of need and the public  
11 health and maybe the understanding of the need for the  
12 information is not as well understood by me as it should be.  
13 The mandate, I think we'd be reluctant to head down that road.  
14 So I guess the question, the first question I would ask if  
15 somebody came into my office and said, "We've got to do this.  
16 This has got to get done, and here is the greater public  
17 health need." The first thing I'd ask is; how do you get the  
18 players lined up so it's valuable to them, because if it's not  
19 valuable to them, then maybe it's not going to be valuable to  
20 us.

21 So as I was listening, I was trying to figure that out.  
22 I just didn't hear it and that's why the response I gave you -  
23 - but the way it was presented maybe to the Health and Social  
24 Services Budget Subcommittee on the House side, they may have  
25 seen the value of saying, "We need this information so that we

1 can make Medicaid decisions, so that we can do a variety of  
2 other things."

3 The Medicaid market certainly is big. Then my next  
4 question would be; okay, how does ANTHC respond to that?  
5 Anybody who gets Medicaid dollars, are they going to be able  
6 to respond? Do they do the reporting now? So that's why I  
7 kind of ended my remark with I'm still learning this, but on  
8 the mandate itself, if the players don't see any great value,  
9 the first question I'd ask is; how do you put that value to  
10 where we all share in it, and if -- I understand there are  
11 sometimes where a mandatory requirement just has to happen.

12 So believe me, I've voted on a couple of them kind of  
13 reluctantly down through the years, but I would look, still  
14 probably very critically at what that take-away value is. So  
15 I understand the CON issue because you really need to know,  
16 but between the hospital stays and the outpatient surgery, you  
17 know, the growing market is changing, but quite frankly, in  
18 Fairbanks, they live under one roof, for the most part.

19 So you know, I don't know what their problem with  
20 reporting would be, but as you have said, and maybe more study  
21 -- this is only my first meeting on the discussion of it. So  
22 maybe I overstated my negative, but that's the barriers I  
23 would have to overcome in thinking it through. So I just  
24 wanted to explain that. I just didn't want it to sound like I  
25 just want to throw cold water on things, but it was my first

1 reaction.

2 CHAIR HURLBURT: And I think the context that -- from the  
3 House Finance Subcommittee, since I'm the one that said that,  
4 was not that they were looking for more regulation, but that  
5 they perceive what we all do, that the current cost structure  
6 is so unsustainable with the tradeoffs and all the rest of our  
7 economy that they would even be willing to consider that.

8 It wasn't -- and it -- it came from the Republican side  
9 of the House there and said, "Yes, we'd be willing to look at  
10 it," but it's because of their acute realization and concern  
11 of the costs that are involved, but I think that it's totally  
12 consistent with what you said, you know, that they wouldn't do  
13 that unless they saw that this was an unusual situation where  
14 there was so much to be gained by doing it that they would go  
15 ahead.

16 MS. ERICKSON: Well, you -- go ahead, Keith.

17 COMMISSIONER CAMPBELL: (Indiscernible - too far from  
18 microphone).

19 MS. ERICKSON: Ward's comment just now prompted a  
20 multitude of thoughts, actually. The -- and I don't know if  
21 you all know what we're talking about, the Monday meeting. I  
22 mentioned it in a couple of different emails to you and I know  
23 you all memorize my emails and Dave was the one Commission  
24 member who actually came, but the -- I think a little more  
25 background on this is important at this point.

1           The House Finance Committee -- the House Finance  
2 Committee breaks up into individual subcommittees around each  
3 individual department's budget, but right now, the Budget  
4 Subcommittee for the State Department of Health and Social  
5 Services is a committee of the whole. So we have all of the  
6 House Finance Committee members on our subcommittee.

7           They decided after this last session that they wanted to  
8 hold -- they are holding three days of hearings a month for  
9 six months and this past Monday, Tuesday and Wednesday was the  
10 first of this series of six, three-day hearings on the  
11 department's budget and they started the first meeting with a  
12 presentation from the Commission.

13           So it was a presentation by me and Ward on the -- what  
14 the Commission has been doing and we actually left all of the  
15 shock and awe out and folks get upset that we make  
16 presentations on the cost of health care and how it's growing  
17 and the impacts.....

18           CHAIR HURLBURT: But we did that during the session, yeah  
19 (affirmative).

20           MS. ERICKSON: We had already done it during the session.  
21 We decided not to repeat it and focus more on the solutions  
22 and at the end of the three days, actually, they suggested  
23 that they want to hold a separate two-day hearing sometime  
24 later in the summer just on the work of the Commission. I  
25 don't know if and when that will happen and who else they

1 might involve, but they -- a few things related to that, they  
2 are very, very serious about wanting to get a handle on  
3 containing the cost growth in the state Department of Health  
4 and Social Services, very serious about it, and the budget's  
5 up to what, two-and-a-half-billion at this point, is that  
6 right or.....

7 UNIDENTIFIED VOICE: Two point seven.

8 MS. ERICKSON: Two point seven billion, thank you, and  
9 the vast majority of that is for the Medicaid program.  
10 Another thing that is happening concurrently, the -- both the  
11 Administration, the Parnell Administration and the Legislature  
12 is taking very seriously -- is a new approach, and I've been  
13 with state government for almost 30 years now and I confess  
14 that I rolled my eyes at one point and then, even laughed at  
15 folks when they brought the book out, because it was the same  
16 book we used five years ago when we went through this, and we  
17 go through this every five years.

18 We're going to do performance measures and we're going to  
19 focus on results based accountability and we're going to  
20 develop results based budgeting. So we've gone through this  
21 process before. We've always had measures in our budget, but  
22 it really feels different this time and it is different this  
23 time.

24 There's another thing -- so the Administration, OMB, and  
25 our department and also the Legislature have been using the

1 same consultant to support helping our agency and other state  
2 agencies with developing new performance measures and both,  
3 effectiveness and efficiency measure.

4 So this gets back to the what do we use the data for? If  
5 we don't have, and I'm sure hospital discharge data is an  
6 important component of the data, one of the data sources, if  
7 we don't have the data, we're not going to be able to report  
8 on either outcomes and potentially some of the activities of  
9 the department, certainly outcomes and most of the  
10 effectiveness measures and the types of evaluations that need  
11 to be done on state programs to determine whether there's an  
12 ROI or not, whether it's worth the investment, we're not going  
13 to have the ability to do that.

14 Commissioner Streur is taking results based  
15 accountability -- real important and is using it as a way to  
16 break down silos between the divisions and getting the  
17 divisions to work together about how the programs contribute,  
18 across the department are contributing to the mission and  
19 redefining mission and services and I was going to mention one  
20 more thing.

21 I know I'm talking too much, but I just wanted to mention  
22 House Bill 30. Could I do that real quick? The Legislature,  
23 in their infinite wisdom, this year passed House Bill 30 and  
24 the Governor has signed it into law now, I believe, that  
25 requires the legislative audit to conduct a year-long

1 performance audit of each state agency and there -- every 10  
2 years, if I remember correctly, and so they're all set up to  
3 cycle through.

4 They're staggered and Department of Health and Social  
5 Services is one of the first and so the department will go  
6 through a year-long audit process during calendar year 2015,  
7 during which time, the auditors will be looking, not just at  
8 administrative functions and performance, but they're going to  
9 be looking at performance measures, effectiveness measures,  
10 whether programs are achieving their stated outcomes or not,  
11 whether they're serving a public good or not, and part of the  
12 audit process will be a requirement to provide the Legislature  
13 with a 10% cut scenario.

14 So all of these -- I wanted to give you more background  
15 on what's going on because there is a very serious and  
16 concerted effort right now to look at getting a handle on the  
17 state's budget. I think we're going to be experiencing some  
18 cuts in the Department of Health and Social Service's budget.

19 I know Commissioner Hultberg has made multiple  
20 presentations to legislative committees, especially State  
21 Affairs, this past year and they're very concerned about the  
22 cost growth and employee health benefits and retiree costs.

23 So all of that as background, both for the data needs and  
24 the importance of the decisions this group is making, if we  
25 just focusing on the problem and then saying, "It's too hard

1 to solve," I -- the Legislature and the Governor are going to  
2 make decisions. They have to. So I -- it's usually easier to  
3 make the easy decisions, which are just cutting programs and  
4 eliminating programs, cutting benefits, reducing eligibility  
5 is the typical response that I've seen in the past to real  
6 hard questions about budget concerns.

7 So I don't mean to be an apologist for these. I try  
8 really hard not to influence, but -- this group, but anyway,  
9 Jim had his hand up and then Dave and I apologize to somebody  
10 on this end of the table, you're going to have to jump up if  
11 you had your hand up, but Jim and then.....

12 COMMISSIONER PUCKETT: I appreciate you supplying some of  
13 that background. I, too, was reticent to say too much, but  
14 just from what I do know of the increase in the expense and  
15 the state budget situation, my hesitancy to impose more  
16 mandates -- I think the problem is going to force the issue,  
17 whether the Commission recommends that they mandate it and  
18 whether they vote it in, I think with the way the healthcare  
19 field is going, I predict consumer driven health care or  
20 health plans are coming.

21 They're going to be more prevalent. I think you would  
22 agree with that. Those value based insurance plans that stick  
23 around, the premiums are going to go up, up, up. I know our  
24 own plan is experiencing the 20% increase and it benches  
25 compared to last year. Those happen. They come and go and

1 we're having one of those right now.

2 So I agree with you. We probably -- she didn't come out  
3 and say it, but the Commission does need to provide something.  
4 I mean, the Legislature is trying to get them information, to  
5 hear from us and so I would say we just -- my feeling right  
6 now is we tell them let's continue with the data -- discharge  
7 database. It's already there and that we take a closer look  
8 at doing an APCD.

9 The consumers are going to demand more information as  
10 they start getting more skin in the game. It's just going to  
11 happen and right now, what it looks like is the best way for  
12 them to get the information is the combination of the two.  
13 The plans will benefit the most from the discharge -- for  
14 their population health data. The consumers will benefit the  
15 most, it looked like, from an APCD of some form and so for  
16 now, I just say we send the recommendation to the Legislature  
17 that we looked more strongly at a discharge and we continue  
18 looking at an APCD.

19 MS. ERICKSON: Dave had his (indiscernible - too far from  
20 microphone).

21 CHAIR HURLBURT: Okay.

22 COMMISSIONER MORGAN: Okay, like I -- like Deb said, I  
23 did attend the first day of this meeting. I also go to a lot  
24 of other things, to the Municipal Finance Director's meetings,  
25 to their state convention, to the underwriters', and we've

1 even had some consumers come in here and talk about -- they  
2 were trying to find out how much, and I can't even remember  
3 what it was, it was either an X-ray, or you know, some major  
4 procedure.

5 I think from what I'm hearing and feeling as I go around  
6 to these different groups is they're going to want to know  
7 someway, somehow, how to make a rationale decision on what  
8 they're going to buy. Sometimes they can't define it, but  
9 they know they want to be able to say, "This one has three  
10 stars and costs \$1,000, and this one's four stars and costs  
11 \$800."

12 You have the specter of the health care insurance  
13 underwriters developing and have developed their own database  
14 and made their own market to make judgements on whether it's  
15 less expensive to put people on planes and send them out,  
16 including the cost of the trip, the spouse, and a couple of  
17 nights in -- and they've made their own network of providers  
18 to catch these individuals when they come back.

19 Adam Smith sometimes actually gets it right. The market  
20 is developing before our eyes. Now, when all this other stuff  
21 hits, from what Dr. Farr is saying and all this other  
22 regulatory -- the markets, the cost, as all this stuff comes  
23 through, plus corrections, administration on the retired  
24 individuals, and I mean, I've gone to three of her  
25 discussions, the Commissioner of Administration, it's not the

1 pensions, it's the health care with the pensions.

2 Then you've got Medicaid, which is getting above, I mean,  
3 it's becoming astronomical and I think everybody is trying to  
4 figure some way to come up with a rational way to make some  
5 decisions.

6 Now, the unrational (sic) way is sequester type stuff.  
7 Hey, we're not going to cover eyeglasses anymore or whatever  
8 it is. I think everybody is trying to come up with a rational  
9 way to put value -- and to make judgements on developing the -  
10 - on the cost side and on the price side. Sometimes price is  
11 the cost.

12 Community health centers, you can walk into any community  
13 health center and all their prices are on the wall and they  
14 always have been that way and their charges equal the cost for  
15 that procedures. They're mandated to do that for their grant.

16 I think consumers, administrators and state government,  
17 with sitting barefoot on billions of dollars, are trying to  
18 come up with a rational way of doing it and what I saw Monday  
19 for the first time, and I've been involved like a lot of you  
20 since the beginning of this Commission, this is the first time  
21 I've ever heard people saying, "Hey, we want you guys to come  
22 up with some stuff on the policy side, not running stuff, but  
23 the policy side to help us make some rational decision."

24 So I mean, we either step up or they're going to find  
25 somebody that will and so that's the question we all have to

1 decide. It's -- I don't think it's going to be a whole lot of  
2 fun, but I think we're going to have to come up with some  
3 stuff.

4 I know mandates are repugnant and I -- whether it's the  
5 discharge stuff or whatever we're going to do, but we've got  
6 to come up with something and we've got to come up with a plan  
7 of -- and we have to be in front of it. If we wait until  
8 they're saying, "Hey, we're ready to make a decision," we're  
9 not going to -- we're going to have two weeks. We're not  
10 going to have -- or even two months.

11 So I know it's bad, but we've got to do -- it's not the  
12 old, "Oh, we've got to do something." We've got to come up  
13 with a rational way of doing this so at least they can make a  
14 book and come up with a rational way of making the decisions.

15 I don't know of -- you'll -- it'll probably surprise you  
16 to hear this, we do, all of us, have some different opinions,  
17 but I would rather this group do that, then a lot of other  
18 groups in the state, because at least, all of us understand  
19 this and work in it.

20 We're not college professors on health care and written a  
21 couple of books, most of us, actually have done it, have  
22 delivered it and whatever that's worth, I can just feel it. I  
23 know that feelings are sometimes a hard thing to quantify, but  
24 I've gone to six or seven state conventions of different  
25 groups from municipal workers to hearing admin to the state to

1 HFMA to MGMA and it's coming and so we've got to do something.

2 Now, what are we going to do, and that's what it comes --  
3 whatever we're going to do, I don't know, but we're going to  
4 have to get in there and get some stuff done.

5 MS. ERICKSON: Okay, Senator Coghill, then Ward, you had  
6 your hand up earlier and Keith's had his hand up, so.....

7 COMMISSIONER COGHILL: So just briefly.....

8 MS. ERICKSON: Okay.

9 COMMISSIONER COGHILL: But that's what I was asking for,  
10 you have to show me what the dramatic impacts are, because a  
11 mandate is dramatic and so I just hadn't heard that in this  
12 conversation today, because we are going to do some dramatic  
13 things and a mandate, though, from my perspective as a state  
14 legislator, the unintended consequences of many decisions have  
15 been regretted down through the years and a mandate is going  
16 to bring consequences that we need to know.

17 So maybe on the principles, you need to put what the  
18 expectation -- and how those expectations are going to be  
19 principally driven for a mandate and then, what the  
20 expectation is, then they can formulate that statutory  
21 provision, but I agree, dramatic issues are going to come, but  
22 to date, I hadn't heard how this reporting is going to help  
23 that dramatic change, so.....

24 COMMISSIONER CAMPBELL: Well, you just heard this morning  
25 Richard Mandsager and John Lee voice their fierce competition,

1 right at the head of this table and you heard Richard say, "As  
2 long as Mat-Su stays out of this reporting system, we're  
3 going," and that's the two biggest in the state.

4 So therefore, you've got not data even to input to get  
5 out any throughput. So it may be a moot point, unless you do,  
6 you know, unless we have to do a mandate, because if those two  
7 are gone, they've never been -- Mat-Su has never been in it,  
8 never been a player anywhere in the politics of state hospital  
9 stuff and -- for what reason, I have no idea, but I know that  
10 Providence is there.

11 Their tentacles are growing all over the state and if  
12 they're out, my little hospital's data is kaput, too, so it's  
13 a gone, moot point. I'm telling you, folks, but if you want  
14 to use this vehicle for doing something, then we're probably  
15 going to have to do something to get the data and that means  
16 making my compadre over here ticked off, probably, but that's  
17 a fact of life. We just heard it this morning. Everybody  
18 heard it.

19 MS. ERICKSON: Ward and then Allen.

20 CHAIR HURLBURT: I think that we've heard that the  
21 hospital discharge database may provide some helpful public  
22 health information, which can inform other decisions  
23 theoretically, at least. It could be helping the certificate  
24 of need process and I certainly have no idea whether it's used  
25 there or not, but it does impose additional workload on

1 providers, on hospitals and anybody else that we get the data  
2 from.

3 Dick Mandsager said, you know, if you're going to do  
4 something, do it like the hospital acquired infections where  
5 it's data we're already reporting, but I don't know that it  
6 is.

7 The all-payer claims database really should be data that  
8 any payer should be tabulating currently and if they're not, I  
9 would say, "Shame on them." They're not being responsible to  
10 whoever's generating the money for their care. So it should  
11 be easier. It's probably also a lot more challenging to  
12 generate sympathy for payers than it is for hospitals, where  
13 you've got the President and the Secretary of Health and Human  
14 Services beating on them all the time, but I think it should  
15 be data that's being generated, but I haven't heard that  
16 either one, in terms of a mandate, is really going to make a  
17 difference now and I don't see how the hospital discharge  
18 database is going to lead to that kind of transparency for  
19 buyers.

20 We haven't heard that the all-payer claims database is  
21 being used that way. The other thing, and Deb, maybe see if  
22 you would agree or not agree on this, but from all we've  
23 heard, if we were going to have an all-payer claims database  
24 to get the ERISA employers involved and everybody else, would  
25 take legislation, which would mean at the earliest, the next

1 legislative session and then signed by the Governor. So then  
2 we're talking about a year from now and probably from other  
3 states' experience, three years to develop it and ramp it up  
4 and to have anything.

5 So we're talking about at the earliest, realistically,  
6 four years from now. Now, if that's the right thing to do,  
7 it's what we ought to do if it would get us to nirvana, get us  
8 to where we need to be. You don't get to that point until you  
9 take the first step, but we haven't heard yet that's nirvana  
10 and that's a really nihilistic statement, I guess, that I'm  
11 making, but I think it reflects the reality that I feel.

12 Do you disagree, Deb, on the three years from other  
13 states' experience of when you start to having a meaningful  
14 (indiscernible - speaking simultaneously)?

15 MS. ERICKSON: Well, no, I don't disagree. I would  
16 imagine it would be about, at the earliest, two years and most  
17 likely, closer to three. I think that's probably, you know,  
18 and one of the benefits of the hospital discharge database is  
19 it is working right now and if there were perhaps a mandate  
20 sometime soon, we'd still get Providence 2013 data and the  
21 other hospitals would continue to participate and I just was  
22 reminded of another indicator that our friends with Healthy  
23 Alaskans 2020 are going to come present to us tomorrow, the  
24 final set of 25 indicators for measuring how the health of  
25 Alaskans is improving over the decade and one of the selected

1 indicators is rate of preventable hospitalizations and one of  
2 the things I really liked about that particular indicator is  
3 that it could drive all sorts of engagement and activity at  
4 the community level around -- and I think it was the very  
5 thing that Marge was asking for earlier today, from the Lung  
6 Association, if we have good data on hospitalizations or  
7 emergency department admissions on asthma, we can better  
8 understand how to target our community efforts to keep folks  
9 with asthma out of the hospital and it's everything from  
10 improving access to primary care and other activities to  
11 support families and individuals with asthma and that's not  
12 government doing those things, but it's government providing  
13 the information so community groups can take that and make  
14 decisions.

15         So if we lose hospital discharge database, we're losing  
16 one of the Healthy Alaskans 2020 indicators and it's probably  
17 the only one on this list that is going to focus on driving  
18 improvements that are focused on our set of strategies right  
19 now, strengthening access to primary care, quality of health  
20 care, and community based prevention and if Dr. Krauss and Ken  
21 Tonjes on the other side was saying, "Yeah (affirmative), he's  
22 right. We need to focus on prevention," if we're not able to  
23 measure, we're not going to be able to focus meaningfully on  
24 it and then we won't be able to tell if we're making a  
25 difference or not and we have a hospital discharge database

1 right now. So that's why -- and it would take three years to  
2 start an all-payer claims database.

3 CHAIR HURLBURT: But in my last job, we had a program  
4 addressing asthma because we were paying ER visits and we were  
5 paying for hospitalizations and we knew we had to target our  
6 population to help them manage their asthma better to keep  
7 them out of the ERs and it wasn't with government provided  
8 data. It was from our own claims base data.

9 MS. ERICKSON: But you were doing that only with your  
10 population.

11 CHAIR HURLBURT: With our population.

12 MS. ERICKSON: And it was patient population in a managed  
13 care organization. So that's fine, if we understand that it's  
14 just the payers and fewer and fewer Alaskans have access to  
15 third-party payers.

16 One of the things that we'll talk about tomorrow is a  
17 study that we're planning on doing with ISER. I'm looking  
18 over at Gunnar Knapp from ISER. He's going to share us a few  
19 minutes about work they're doing to build some capacity for  
20 health economic research and I'm already working with him.

21 I'm trying to -- looking at doing an employers' survey to  
22 get a better understanding of -- I mean, we all know why, but  
23 Alaskans and small employers are rapidly discontinuing  
24 providing health benefits for their employees because they  
25 can't afford it anymore.

1           So more and more Alaskans are going without insurance and  
2 if the only way to get at effective health management for  
3 improving the health of a patient population is through a  
4 managed care organization or through the third-party payer,  
5 then we're leaving a lot of folks in the state out and I think  
6 that's probably a good example of how that data could be used  
7 at the community level, and again, it's not the government  
8 doing it, but it's the government facilitating it by providing  
9 the information as a foundation. Are we debated out? Allen.

10           COMMISSIONER HIPPLER: I apologize. I have to say  
11 something. My friend, Mr. -- Commissioner Morgan said  
12 something that always terrifies me when a government  
13 commission says it and it's, "But we must do something."

14           That phrase almost always comes from the government  
15 creates a problem, says, "Oh, no, there's a problem. We must  
16 do something," and the solution is we either spend the  
17 government's money, which is really mine, or we impose more  
18 regulations to fix the problem, which -- and this is our --  
19 the solution. We force people to participate in the discharge  
20 data.

21           The immediate effect of this will be an increase in cost.  
22 Now, I admit that Mat-Su Hospital probably won't even notice  
23 the increase in cost for them, because they have the  
24 capabilities. It probably wouldn't be a big deal, but if we  
25 extend it to more than the hospitals to make it meaningful,

1 that will have a very significant impact on these smaller  
2 providers.

3 It will have a significant increase in cost. So that's  
4 okay, I guess, if we were getting a tangible benefit from it,  
5 so that our legislators could use this data to make their  
6 decisions and I'm not seeing that come from the hospital  
7 discharge data at this time.

8 So I had to get that out and then there's one other  
9 thing. The all-payer claims database, I know we're not  
10 talking about that now, but I just -- I wanted to -- I want to  
11 say that I see a lot of value in this in the future.

12 I think it's -- the all-payer claims database is like one  
13 blade of scissors. It gives data to people to price shop and  
14 quality shop. The problem -- and that's one blade of the  
15 scissors, but the other blade is people who want to price shop  
16 and we don't have that quite yet, but with the Affordable Care  
17 Act, which I think will result, actually, in more people  
18 without insurance and more people price shopping, that other  
19 blade could come into place and this could be a very valuable  
20 tool tomorrow, not today, you know, a couple of years from  
21 now, not today.

22 So I -- and Mr. Puckett was pointing out that there is an  
23 increase in people with, what he called consumer driven plans,  
24 which I think really means high deductible, where the  
25 consumer's really paying attention and so I see a lot of

1 potential for that tomorrow.

2 COMMISSIONER URATA: Do you want a motion?

3 MS. ERICKSON: No, I don't want -- unless it's to adjourn  
4 for the day, to recess for the day. We will accept a motion.  
5 You do not need to feel compelled to make one, however, and  
6 just as a reminder, we missed the last 15 minutes of the day,  
7 but we talked about some of what we're going to talk about and  
8 it will take us a minute to vote in the morning.

9 We'll vote on the bylaws in the morning, but -- and I'm  
10 not cutting off your motion, Dr. Urata, I just wanted to point  
11 out, our plans for the morning is to continue this discussion.  
12 So we'll regroup here at 7:30 for breakfast and gavel in at  
13 8:00 and spend an hour, after we've had a chance to sleep on  
14 all of this, continuing this conversation.

15 CHAIR HURLBURT: Did you want to make a motion?

16 COMMISSIONER URATA: Well, I was thinking of -- that I  
17 need to go to the restroom soon, so if were going to talk, I  
18 was going to make a motion for a five-minute break.

19 CHAIR HURLBURT: Okay.

20 MS. ERICKSON: It's time to recess, just with a reminder  
21 though,.....

22 COMMISSIONER URATA: I'll make a motion for the recess,  
23 then.

24 MS. ERICKSON: .....that 60 -- when we looked -- when  
25 ISER looked at it in 2004/2005, no, the 2010 data, 64% of all

1 of the health care spending in this state was by government,  
2 some level of government.

3 CHAIR HURLBURT: Yeah (affirmative), on an -- and on an  
4 international basis with our private sector system, we spend  
5 more in dollars and -- for public sector health care than  
6 every other industrialized country, except Norway, plus we  
7 spend all -- for private insurance that the other countries  
8 don't spend.

9 So it's not that we don't have a humongous public sector  
10 paying for health care. It's bigger than all of the other  
11 industrialized countries in terms of dollar equivalence. So  
12 that's fortuitous.

13 COMMISSIONER URATA: (Indiscernible - too far from  
14 microphone) and they still pay the cost (indiscernible - too  
15 far from microphone).

16 CHAIR HURLBURT: I hear a motion to adjourn.

17 MS. ERICKSON: No, we're not adjourning on (indiscernible  
18 - too far from microphone).

19 CHAIR HURLBURT: We're recessing. A motion to recess.

20 UNIDENTIFIED VOICE: (Indiscernible - too far from  
21 microphone).

22 CHAIR HURLBURT: Second.

23 UNIDENTIFIED VOICE: (Indiscernible - too far from  
24 microphone).

25 CHAIR HURLBURT: Okay, see you in the morning. Thank

1 you, all, very much.

2 4:36:25

3 (Off record)

4 **SESSION RECESSED**

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