

Erickson, Deborah L (HSS)

From: Michael DiFilippo <Michael.DiFilippo@healthsmart.com>
Sent: Friday, November 08, 2013 2:07 PM
To: Erickson, Deborah L (HSS)
Subject: AHCC

Hello Deborah,

Great job with the Alaska Health Care Commission's 2013 Draft Finding & Recommendation statements and preliminary plans! I got an email about it yesterday and had a chance to read it very early this morning after my son woke me up :)

Have a good weekend!

Mike

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Erickson, Deborah L (HSS)

From: Richard Holt <dokholt@mac.com>
Sent: Monday, November 11, 2013 6:45 PM
To: Erickson, Deborah L (HSS)
Subject: Alaska Health Care Commission's 2013 Draft Finding and Recommendation

Dear Ms. Erickson,

As your team has discussed in the Alaska Health Care Commission's 2013 Draft Finding and Recommendation report prescription drug abuse is a significant issue not only in Alaska but nationally.

An additional approach that I would like to see the Alaska Board of Pharmacy to pursue, with the assistance of the Alaska Medical Board, is to mirror the recent 2013 control substance monitoring program in New York State. The recent 2013 legislation in NY states that, "Effective August 27, 2013, practitioners will be required, with limited exceptions, to check the PMP Registry prior to writing a prescription for a controlled substance in schedule II, III, and IV for a patient." Similarly, pharmacists have access to this real time database. More information regarding the NY PMP Registry can be found at: https://www.health.ny.gov/professionals/narcotic/prescription_monitoring/

In addition, there are two others steps that can be introduced in an attempt to limit prescription abuse. These include:

- 1) Requiring standardized prescriptions available to order through the state. NY has implemented this program as well in order to cut down on fraudulent prescriptions.
- 2) Requiring the actual DEA license holder to phone in verbal orders on control substance prescriptions.

Combatting prescription drug abuse needs to be a team effort between the Medical and Pharmacy Boards to implement measures that will enhance patient outcomes and limit patients who are doctor shopping. This two armed approach will truly limit a patients ability to doctor shop for multiple control substance prescriptions.

Thank you for your time,

Richard Holt, BS Pharm, PharmD, MBA
Pharmacist
Ketchikan, Alaska

Erickson, Deborah L (HSS)

From: David Donley <dd1@gci.net>
Sent: Tuesday, November 12, 2013 2:04 PM
To: Erickson, Deborah L (HSS)
Cc: Bylsma, Rachel E (GOV)
Subject: From Dave Donley Comment on Draft Health Care Report
Attachments: 2013 Denali Kid Care Bulletin.PDF

Deborah

I find the following bolded sentence in section E. to be highly misleading with resulting inaccuracy.

E. Market forces affecting pricing for health care services are influenced by the size and structure of Alaska's health care market.

...

The State of Alaska Department of Administration has 17,000 active employees and dependents on the active employee health plan and 31,000 early retirees (under 65 years-of-age) and dependents on the retiree health plan. **The non-diminishment clause pertaining to retirement benefits in the State Constitution restricts the Department of Administration's ability to implement strategies that could help to improve the retiree plan and contain costs.**

The non-diminishment clause does not prohibit the State of Alaska from improving retiree health insurance coverage. It only prevents the state from making the coverage worse. At any time the state by a simple letter to the health insurance administrator (as the state has done in the past for active employees i.e. adding "well baby care") could add cost saving preventive care coverage such as that provided by Denali Kid Care: well baby care, immunizations, colonoscopy, reasonable wellness physicals.

The fact is the state has chosen not to add these cost saving coverages **because the Department of Administration is trying to use them as a bargaining tool to get retirees to agree to reduce other coverages.** I know this for a fact from direct conversations with the current and last Commissioner of Administration.

It is incredibly unfair for state retirees to have no preventive care when Denali Kid Care provides it and **actively solicits its recipients to use it.** See attached flyer.

Without revision this sentence is extremely biased and misleading. Please revise this sentence to make it truthful and fair. I suggest:

The non-diminishment clause pertaining to retirement benefits in the State Constitution restricts the Department of Administration's ability to reduce existing coverage. The Department has opposed implementing strategies that could help to improve the retiree plan and contain costs without reducing other existing benefits.

Dave Donley
Senator and Representative Alaska Legislature 1987 - 2002

10-20 year Old Edition 2013



Denali KidCare/Medicaid HealthCheck News

Good News! Expanded Orthodontia services are now available under Denali KidCare/Alaska Medicaid

In November 2009, a superior court judge ordered the State of Alaska to "provide reimbursement for any dental service, including orthodontia, provided to Medicaid recipients under the age of 21 which at a minimum includes relief of pain and infections, restoration of teeth, and maintenance of dental health."

Accordingly, Denali KidCare/Alaska Medicaid will cover orthodontia services for children and teens under 21 years of age. Putting braces on children's teeth is called orthodontia and Medicaid requires these services to be performed by an orthodontist who is enrolled in the State's Medicaid program. Braces are appropriate for children and teens that may have a severe problem with their teeth.

Generally, younger children may be eligible for specialized services called Limited or Transitional Orthodontia. These services may include braces to:

- Redirect poorly emerging teeth
- Correct an improper bite
- Create space for adult teeth

Generally, teens and young adults may be eligible for specialized services called Comprehensive Orthodontia. These services may include braces and/or other treatment to:

- Improve a severe problem with adult teeth
- Correct a complex medical condition

Orthodontia will not be approved solely for cosmetic or esthetic reasons. Contact your orthodontist to see if this service is right for your child.

If your child applied for braces or another type of orthodontia care prior to November 2009 and was denied coverage for services, you or your orthodontist are encouraged to reapply for services. You may contact the Recipient Helpline for more information at 800-780-9972 or RecipientHelp@xerox.com

Smiles for Life

Tooth decay is one of the most common preventable diseases seen in children today. Cavities in teeth can cause pain and prevent children from being able to eat, speak, sleep and learn properly. Denali KidCare/Medicaid recommends that all children receive fluoride varnish to prevent new cavities and help stop cavities that may have already started.

Fluoride varnish is a protective medication that is painted on teeth to prevent cavities. It is quick and easy to apply, does not have a bad taste and there is no pain. Contact your dentist, health aide or other health care provider to see if this service is right for your child.



Choosing the Right Healthcare Provider

It can be hard to find a health care provider that is right for your family. Ask for recommendations from family, friends, or co-workers. Select a provider that you can build a trusting relationship with and can relay your questions and concerns to. Consider the office hours and location when making your selection. If you need additional resources please contact the Recipient Helpline by phone at 800-780-9972 or by e-mail at RecipientHelp@xerox.com

Eye Care Coverage

Denali KidCare/Medicaid covers eye exams and eye glasses. Important things to know about your coverage:

- One company makes all of the eyeglasses that Denali KidCare/Medicaid buys. The same eye doctor that gives you a prescription can order your glasses
- Denali KidCare/Medicaid covers only certain frames. Popular styles are available for boys and girls of all ages. Scratch-resistant coating on plastic lenses is included for anyone under the age of 21
- If you want different frames or a feature that is not covered, you will need to pay the entire cost of the glasses yourself. The amount that Denali KidCare would have paid can't be applied to the cost of other glasses
- Denali KidCare/Medicaid does not usually pay for contact lenses
- Denali KidCare/Medicaid does not pay for progressive lenses
- If your child has special vision care needs or breaks a pair of glasses, your eye doctor will work with Denali KidCare/Medicaid to get more services approved

Feel Great and Look Good

Healthy eating habits and physical activity work together for better health. Making healthy food choices helps your child grow, develop and be ready to learn in school. To learn more about healthy eating check out this website: choosemyplate.gov.

Useful Contacts:

Recipient Helpline Information about Denali KidCare/Medicaid billing, help in finding a provider and coverage questions	800-780-9972	RecipientHelp@xerox.com
Denali KidCare Program Applications & enrollment questions	269-6529 888-318-8890	denali.kid.care@alaska.gov
Well-Child Travel Program Local transportation assistance	269-4575 888-276-0606	Hcs.wellchildtrans@alaska.gov
Immunization Hotline	269-8088 888-430-4321	

Well-Child Checkups are for Teens and Young Adults Too!

Denali KidCare/Medicaid pays for your child's well-child checkups. It is important for your child to see a health care provider when he or she is sick, but it is just as important for them to go when they are feeling fine. A well-child checkup helps to detect any problems early and keeps them up-to-date on their immunizations. Regular checkups will also ensure your child has a healthcare provider who knows them well.

What happens during a well-child checkup?

- You can ask any questions you may have
- Head to toe exam
- A Developmental Screening to detect whether your child is learning and growing appropriately
- Receive important childhood immunizations
- Discuss nutrition and exercise
- Assess your child's behaviors and emotions
- Vision and hearing screening
- Dental screening
- Referrals to a specialist if needed
- Learn what to expect as your child grows

When should your child have a well-child checkup?

The American Academy of Pediatrics recommends children receive a well-child checkup every year from 10 to 21 years old.

Immunizations Save Lives

Protect your child at all ages. Diseases like measles, polio, and whooping cough (pertussis) still exist. Immunizations protect children and adults from these and other serious but preventable diseases. Ask your health care provider at every checkup to make sure that all immunizations are up-to-date. Go to <http://www.epi.hss.state.ak.us/id/iz/schedule.pdf> to view the Immunization Schedule for your child. For more information call the Alaska Immunization Helpline at 269-8088 or toll free 888-430-4321.

Local Transportation Assistance

Denali KidCare/Medicaid offers bus passes, mileage reimbursement or taxi rides to and from medical or dental appointments. This assistance is available to children under 21 or pregnant women who are currently eligible for Denali KidCare/Medicaid. Remember, Denali KidCare/Medicaid will approve the least expensive method of travel available in your community. For travel within the Anchorage area contact the Well Child Transportation program by phone at 269-4575, toll free at 888-276-0606, or by e-mail at Hcs.wellchildtrans@alaska.gov. For travel outside the Anchorage area contact your local Public Health Center. You can find information about your local Public Health Center at <http://dhss.alaska.gov/dph/Nursing/Pages/locations.aspx>. A minimum of one business day advance notice is required to facilitate transportation requests. Business hours are Monday through Friday, 8am to 4:00pm.

Erickson, Deborah L (HSS)

From: Love, Jenny G (HSS)
Sent: Wednesday, November 20, 2013 3:11 PM
To: Erickson, Deborah L (HSS)
Cc: Hale, Ron B (HSS)
Subject: Health Care Commission Draft comments

Greetings Deb!

I was reviewing the public draft of 2014 recommendations/plans for the AKHCC and only had one comment:

In Part III. Draft Commission Plans for 2014—I do not see any notation of reviewing the current status or possible recommendations regarding Behavioral Health access in Alaska.

Granted, my perspective is biased, however I suspect with the changes to Grantees by DBH, ACA reform and the ongoing lack of skilled behavioral health providers in rural and urban settings, there is an increased risk of detriment to the well-being of all Alaskans. The interrelationship of behavioral health, emotional wellness and physical health is established in the medical literature. Part of the reduction of overall health costs, increased perceived (and measured) wellness in the population, and economic viability (i.e. health workers) of Alaska is intimately related to behavioral health.

I would hope that the Health Care Commission would continue to maintain vigilance to the behavioral (mental/emotional) well-being of Alaskans as well as their physical health and economic well-being.

Thank you for your work on the Commission and I look forward to seeing developments in 2014!

Jenny G. Love, MD, MPH

Medical Director
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Erickson, Deborah L (HSS)

From: Lee, John R. <j.lee@msrhc.com>
Sent: Monday, November 25, 2013 3:25 PM
To: Erickson, Deborah L (HSS)
Subject: Public comment on Draft 2013 Findings and Recommendations

Deborah,

Thank you for the opportunity to provide comment on the 2013 Findings and Recommendations issue by the Alaska Health Care Commission.

I would like to provide comment on the recommendation of mandated participation in the Hospital Discharge Database program. As you are aware, I provided testimony on this issue at a public meeting earlier this year. I would like to repeat some of the points I made during this testimony.

The state needs accurate and complete data in order to effectively make policy decisions on important matters of public health. Not all hospitals in the state submit data to the Hospital Discharge Database program. I am not aware of any outpatients surgery or imaging centers in the state that submit data to the Hospital Discharge Database program.

The current healthcare environment has resulted in a large percentage of healthcare being delivered in an outpatient setting. These settings include outpatient ambulatory surgery centers and outpatient imaging centers. Omitting this data in any state-wide database system would be a significant deficiency and render decision making based on hospital-only data limited at best. I propose all entities that operate under a CON be mandated to report to the state's discharge database. Additionally, a significant percent of healthcare is delivered in Native and Department of Defense facilities in Alaska. As such, I also propose that any entity that would otherwise be required to operate under the CON but do not due to their Native or Department of Defense status be required to report their data to the state database as a condition of receiving state Medicaid reimbursements.

Currently the state hospital association collects this discharge data. Not all hospitals in the state are members of this association. Currently, the state association only shares data with member organizations. I propose the state manage this database in order to remove potential conflicts with how the data is used and who the data is shared with. The state should establish an independent oversight committee to manage data requests to ensure all in the state have equal and fair access to the data in a consistent manner.

John Lee | Chief Executive Officer | Mat-Su Regional Medical Center
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Erickson, Deborah L (HSS)

From: Karen Perdue <karen@ashnha.com>
Sent: Wednesday, November 27, 2013 11:28 AM
To: Erickson, Deborah L (HSS); Jeannie Monk
Cc: andrew.mayo@uhsinc.com; Rick Davis; Robert Letson; richard.mandsager@providence.org; MIKE.POWERS@bannerhealth.com; Rush, Donald
Subject: Comments from ASHNHA on the HCC findings
Attachments: ASHNHA_Comments_Health Care Commission 2013 11-26-13.docx

Deb, here are ASHNHA's comments on the 2013 HCC draft. I have copied key members of our Executive Committee as well. Happy Thanksgiving to you.

All the best, Karen

Karen Perdue
President/CEO

ASHNHA: Celebrating 60 Years

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426 Main Street
Juneau, Alaska 99801



**Comments on the Alaska Health Care Commission 2013 Draft Plan
Alaska State Hospital and Nursing Home Association
November 27, 2013**

Thank you for giving us the opportunity to comment on 2013 Findings and Recommendations. Below are our comments on the draft findings, recommendations, and future plans for the Health Care Commission.

Strategy B: Engage employers to improve health plans and employee wellness.

Recommendation #1: Mechanism to provide the public with information on prices, quality and outcomes (Page 11)

a. Immediately proceed with caution to establish an All Payer Claims Database and take a phased approach.

ASHNHA Comment on Recommendation:

ASHNHA supports increased transparency, but the APCD is a large, very expensive and time consuming effort and will be challenging to achieve the desired results. The states that have been working on APCDs for many years are showing only mixed success at using the APCD to provide the public with information on price, quality, and outcomes.

ASHNHA believes there are still many unanswered questions and issues to resolve before a decision is made to “immediately proceed” with an APCD. We recommend the development of a stakeholder process that extends beyond and is separate from the Health Care Commission. This stakeholder group could more fully develop a plan for an APCD including a clear statement on what goals and outcomes the APCD seeks to achieve, how the effort will be funded, and a timeline for implementation.

The APCD would consolidate virtually all the financial and utilization data of a \$7 billion dollar industry into one large bucket, potentially operated by government. It is absolutely essential that providers, among others, understand and agree on the purposes and generally on the operating principles of the data base.

The stakeholder process should also look at more nimble enterprise solutions that are coming on the market to consolidate and display information to consumers in a meaningful way as a means to empower consumers.

ASHNHA recommends focusing first on the Hospital Discharge Data System and making sure this effort engages stakeholders and achieves the desired outcomes. After this system is established, then consideration of an APCD would be appropriate. All of the States working on APCD have solid, long standing discharge reporting systems in place. Trying to do both at the same time maybe unrealistic and starting with the APCD without the solid

experience and success with discharge data is unwise.

Recommendation # 4: Enact changes in Worker’s Compensation Act to continue medical costs and improve quality of care and outcomes (page 11)

ASHNHA Comments on Recommendation #4:

We support reasonable reform of Workers Compensation elements outlined in the recommendations. Reform to the system appears overdue. With that in mind, care should be taken to implement reforms to fee schedules and other elements that are balanced and do not impose such significant reductions in provider reimbursement that they cause patient access problems.

Strategy C Increase price and quality transparency; and strengthen the health information infrastructure

ASHNHA Comments on Strategy C Findings:

- 1. Findings related to Hospital Discharge Database** (page 13 the 4th bullet point). Important to note that the data set is incomplete not only due to the lack of full participation by all hospitals, but also due to lack of inclusion of data from ambulatory surgery centers providing some of the exact same procedures done in hospitals.
- 2. Finding related to All Payer Claims Database**
The presentation on the APCD also indicated that states that have implemented APCD have had mixed results and faced many challenges in using the data from an APCD to impact consumerism in the health care market. It is important to acknowledge the challenges and mixed success faced by other states that have worked for many years to implement APCDs.

ASHNHA Comments on Recommendations

Recommendation #1: Mandate participation in the Hospital Discharge Database for the purpose of providing data that will lead to health care policy decisions that will improve the health of Alaskans and to encourage federal facility participation in the database.

ASHNHA supports changes in the discharge database that will ensure all facilities providing the same services as hospitals are mandated to report. This means the mandate must include ambulatory surgery centers. Increasingly outpatient clinics and surgery centers are doing more procedures in their offices that previously were provided in hospitals. It is critical that these facilities have the same reporting requirements for the same procedures as hospitals. The mandate should consider other facilities that provide the same services as hospitals such as birth centers and imaging centers and in the future specialty hospitals.

During this transition from a voluntary to a mandatory system we will be looking for meaningful engagement of the reporter industries in the design of the protocols for data

privacy, security and use of data for research or public purposes. So far, we do not have clarity that such a process will occur since there is no mention of such a process in the recently released draft regulations.

For the last decade, ASHNHA has been a partner with the State in collection and use of the data. In July of 2013, the State took back full management of the data system in preparation for a mandatory system. It is essential that a data governance structure be instituted that will give those who report a meaningful say in the protocols used to collect and disseminate the data since there is currently and for the first time in the history of the Alaska hospital discharge system no formalized industry involvement in the discharge system.

How consultation is conducted on conversion to the mandatory discharge system will help us form an opinion about how likely industry or stakeholder consultation will be conducted on larger data projects.

To provide more detail on mandated reporting attached is the stakeholder input ASHNHA provided to the State DHSS.

ASHNHA Comments on DRAFT Commission Plans for 2014

Affordable Care Act

We would like to see the Health Care Commission take a more active role in federal health reform activities in Alaska. Simply tracking the activities is no longer enough. We believe the Health Care Commission could take a more active role in informing the public of the decisions and actions ahead.

Previously the Commission determined that “Health insurance coverage in Alaska is inadequate” (Summary of prior year findings). We would like to see the Commission focus on supporting Alaskans to purchase health insurance through the federally facilitated health insurance marketplace and gain access to subsidies to make insurance more affordable. A coordinated, statewide marketing and education campaign is necessary to help Alaskans understand the health insurance mandate and the subsidies available. We would like the Commission to study the concept of Alaska taking on a partnership role with the federal government to improve the health insurance marketplace and ensure the website meets the needs of Alaskans.

We are concerned about the Governor not accepting the Medicaid Expansion for Alaska and the resulting “coverage gap” for Alaskans below 100% of the federal poverty level (FPL) who cannot access Medicaid and are not eligible for subsidies to purchase insurance through the marketplace. We would like the Commission to study the population that will not have access to insurance or Medicaid and come out with a recommendation on the best way to meet the needs of some of the most vulnerable Alaskans.

Overall, as implementation of the Affordable Care Act continues, we recommend the Health Care Commission identify the implementation activities that are aligned with the

Commission's vision and goals and enthusiastically support these activities.

Submitted by:

Karen Perdue/ President and CEO
November 27, 2013

Attachments:

ASHNHA Stakeholder Comments on Discharge Database

State DHSS Stakeholder Teleconference Hospital Discharge Data Reporting System Input from ASHNHA – August 2013

Hospitals generally support a transition to a mandated discharge reporting system but have a few concerns that we would like considered as the regulations are drafted.

Reporting Facilities

- The mandate must include ambulatory surgery centers. Increasingly outpatient clinics and surgery centers are doing more procedures in their offices that previously were provided in hospitals. It is critical that these facilities have the same reporting requirements for the same procedures as hospitals.
- DHSS regulations for reporting should consider other facilities that provide the same services as hospitals such as birth centers and imaging centers.
- Currently many federal and tribal facilities have not been reporting discharges. Since a comprehensive census has been stated as a desired outcome, it is important that a mandate be applied equally to all facilities providing the same procedures including tribal and federal facilities.

Data Standards & Submission

- Adopt national data standards that are HIPAA-compatible.
- Provide flexibility on data submission timelines. Quarterly submission may facilitate increased use of the data, but might be a large burden on small facilities with limited staff capacity. Submitting quarterly may be more time consuming than an annual submission. Use technology to allow on-line, streamlined submission processes to reduce burden on reporting facilities.
- Provide a process for data review and validation to ensure the reporting facility has the opportunity to validate and correct data and review results/comparative reports prior to release. This will assure the underlying data sources are as accurate and complete as possible.

Data Governance

- Hospitals would like to know there will be a robust process for determining appropriate uses of the data and what data should be released. This process needs to be codified in the regulations.
- In the past, the State has handled hospital discharge data very responsibly. However, as DHSS faces staffing changes (Alice's retirement) it is important to have policies and processes in place that continue the responsible use of industry data.
- ASHNHA would like an External Data Oversight Council included in the regulations with representation from industry stakeholders. The Council would establish a plan that defines how and what data will be collected and released, who

will have access, and how open source analytic tools and measures can be incorporated.

- Other states have models for data councils and processes that support strong data governance, we would encourage the State DHSS to look to other successful state models that have robust governance processes.

Data Release and Access Provisions

- Data release policies must balance the utility and privacy of the data. Stakeholders need to have a voice in determining the release policies through a data council type process.
- How will policy makers get access to data? Need processes in place authorized through a data council to ensure data is not used for political purposes.
- Classify the underlying master file or identifiable database as non-discoverable and not subject to state freedom of information act. Provide a liability clause for providers required to submit data.
- ASHNHA would like to continue to receive high level summary reports with member hospital data.
- Hospitals would like to continue to receive hospital specific and statewide summary reports to use for planning and market analysis purposes. There will need to be a process for hospitals to request special data reports based on the data use agreements.
- Will the state publicly release provider-level comparative data? It will be important to look at best practices for the release of data where the numbers are small. Data release policies must address the issue of small numbers of discharges – especially in communities with only one hospital. If data is available by geographic region, then data will be identifiable by most facilities (other than Anchorage).
- How will data from outlier facilities that do not have a comparable facility in the State be handled? For example, North Star Behavioral Health is the only youth behavioral health hospital in Alaska so even data released on a statewide basis will be identifiable.
- Hospitals that are new to the discharge reporting process have concerns that hospital specific information might be released to a competitor or a vendor without their knowledge, the data release policies need to clearly outline how data will be released.
- Look to the experience of other states to find out how they have addressed the small number or single facility issues.
- The data should not be for sale to outside vendors.

Erickson, Deborah L (HSS)

From: Patricia Senner <paksenner@gmail.com>
Sent: Wednesday, November 27, 2013 12:07 PM
To: Erickson, Deborah L (HSS)
Subject: Comments Alaska Nurses Association on the Alaska Health Care Commission Recommendations
Attachments: AaNA Comments Alaska Health Care Commission 2013 Recommendations.docx

Deborah, Thank you for giving the Alaska Nurses Association the opportunity to comment on your 2013 recommendations. Many of your recommendations involve the nursing profession and we are more than willing to work with the Commission on shaping and implementing these recommendations. Patricia Senner, RN, ANP



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(907) 274-0827
www.aknurse.org

Comments of the Alaska Nurses Association

November 27, 2013

Alaska Health Care Commission 2013 Findings and Recommendations

1. We are in support of evidence-based medical and nursing care, however there are some severe limitations to this approach. A good example comes under the recent recommendation regarding screening for prostate cancer. The recommendation against using PSA for screening for prostate cancer was based on two studies – the ERSPC in Europe and the PLCO trial in the US. Both of these studies involved mostly white men.

In the United States the incidence of prostate cancer in African American men is 27% higher than for white men. **In the US the age adjusted prostate cancer mortality rate for African American men is more than twice that of white men.** For black men in Alaska, findings from studies done on prostate cancer screening for white men in Europe may not be applicable.

Alaska has a very racial/ethnically/culturally diverse population. Is it safe to extrapolate from studies done on a less diverse population to Alaska?

2. Prior authorization processes are one of the most time consuming, and therefore financially consuming, factors for Alaska health care providers and their patients. These requirements lead to gross inefficiencies. You could spend a year just investigating and make recommendations on this topic.
3. The Alaska Nurses Association would like to be involved in the process of developing skill development opportunities for nurses on decision-making related to payment for medical/nursing services. We have an active CE program and could help disseminate these learning opportunities to nurses.

In general we think you should use the term health care services rather than medical services. There are many different players in the health care system other than physicians.

4. Nurses are frequently on the front line for assisting patients with finding ways to be compliant with health care plans. We hope you involve nurses and persons with health challenges in the process of developing tools for making compliance/ health improvement strategies easier for the provider and patient.
5. Related to the issue of employers and health plans, providing a safe working environment is one of the top priorities of the Alaska Nurses Association. Injuries related to lifting and turning of patients in hospitals and other health care facilities is a huge problem and we would love to have the opportunity to work more closely with employers of nurses on this issue.

6. Because they can no longer lift or turn heavy patients, nurses frequently have to retire before age 65. If these nurses have worked in the private sector it is difficult for them to get health insurance. The Affordable Care Act will make insurance available to many of these nurses. We wish the state Alaska Administration would stop maligning this program when they have no alternative.
7. In regards to workers compensation claims, we think there needs to be an incentive for employers to make improvements in their work environments to reduce injuries. It appears to us that employers are often willing to pay high claims rather than invest in equipment that would reduce injuries. We want to see more lift equipment installed in Alaska's hospitals and nursing facilities.

Regarding costs of workers compensation, Alaska RNs who work on the road system are paid the same or less than their counterparts in Seattle and Portland.

8. That Alaska Nurses Association would love to work with other providers on developing a system to improve pain control without overdependence on opioids. Caring for persons who have become addicted to opioids is one of the most difficult tasks facing nurses in this state.

There currently isn't any stable funding for the Prescription Drug Monitoring program operated by the Board of Pharmacy. Having a database that one can consult before prescribing opioids is an important first step in curbing inappropriate prescribing. Making this realtime may be difficult, but worth investigating.

You mention the legislation that Washington State passed in an attempt to curb their opioid abuse problem. While there have been some successes from this legislation, it has made it more difficult for patients with pain to obtain treatment, especially those located outside large urban areas.

9. The Alaska Board of Nursing does have regulations regarding dispensing of medications (12 AAC 44.447. ADVANCED NURSE PRACTITIONER DISPENSING STANDARDS). We are not exactly certain what you feel needs to be added. The Board or Nursing, the Medical Board, and Board of Dental Examiners may not have any statutory authority to regulate pricing of services such as repackaging fees provided by their covered health care providers.
10. The Alaska Board of Nursing has an advisory covering prescription of opioids for treatment of pain. See:
http://commerce.alaska.gov/dnn/Portals/5/pub/APRN_Advisory_Pain_Management.pdf.
These may need to be made put into regulation.
11. When dealing with the opioid abuse problem one needs to keep in mind the complexity of the problem. Washington State based their plan to reduce opioid abuse on the findings of a task force that included representatives from many different health care professions, including nursing. We would suggest setting up a similar commission here in Alaska.

We look forward to working with the Commission on these difficult issues over the coming year.

Erickson, Deborah L (HSS)

From: Julie Lynch McDonald <julie.cpfi@gmail.com>
Sent: Wednesday, November 27, 2013 1:37 PM
To: Erickson, Deborah L (HSS)
Cc: Nancy Davis
Subject: Alaska Pharmacists Association Comments for AHCC
Attachments: AkPhA Comments for AHCC.doc

Dear Ms. Erickson

Thank you for allowing the Alaska Pharmacists Association to comment on the Alaska Health Care Commission's 2013 Draft Findings and Recommendations. Please refer to the attached letter and feel free to contact me or the association for any needed clarification. We look forward to working with you.

Sincerely,

Julie McDonald, Pharm.D.
President, Alaska Pharmacists Association



Alaska Pharmacists Association

November 27, 2013

Deborah Erickson, Executive Director
Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-5923

Dear Ms. Erickson;

The Alaska Pharmacists Association (AkPhA) appreciates the opportunity to submit comments on the Alaska Health Care Commission's 2013 Draft Findings and Recommendations. Pharmacists are known as one of the most trusted professions and the most accessible health care professional. As a result, AkPhA hopes the commission will carefully consider the following comments and ensure practicing pharmacists are included in the commission's discussions.

- Page 6 Part II: Ensure best available evidence is used for making decisions – Recommendations
 - Section 1a the final bullet discusses making prior authorizations “efficient, prompt, and user-friendly for providers and patients”.

Pharmacists are often the first to know a prior authorization (PA) is required. Consequently, pharmacists serve a pivotal role providing essential PA information to prescribers including suggestions of alternative medications if appropriate. Pharmacists are frequently responsible for explaining the PA process to patients. Also, pharmacists determine if providing a short supply of medication is necessary while waiting for a PA approval.

AkPhA supports improvement of the PA process and the association would like to see the process become more standardized. AkPhA recommends practicing pharmacists be included in discussions on improving the PA process.

- Section 1c mentions involving health care providers in training and decision-making regarding application of evidence-based medicine to public policy.

AkPhA appreciates the commission's efforts to include health care providers and especially pharmacist in this process.

- Section 1e states promote provider-patient relationships through payment structures and benefit designs... related to compliance and chronic diseases state management.

AkPhA truly values the pharmacist-patient and pharmacist-prescriber relationships, which is why third party dictated use of out of state mail order pharmacy is of great concern! Third parties frequently regulate patient use of mail order pharmacies, which are owned by the third party or Pharmacy Benefit Manager (PBM). The commission should oppose this growing trend and support a patient's choice to use a local pharmacy when available or at minimum an Alaska pharmacy that mails prescriptions.

E-mail: akphrmcy@alaska.net

When out of state mail order pharmacies (mail order) are used, prescriptions are often delayed or lost, there is no personal pharmacist-patient nor pharmacist-prescriber relationships, duplicate or discontinued medications are frequently mailed without patient request, discontinuing medications had been refused even when called by prescribers, there is a lack of familiarity with local providers' prescribing habits which leads to increased medication errors, weather delays and/or po box delivery can damage medication quality sometimes beyond the point of safe use, and counseling is not personally tailored nor is it conducted face to face therefore patient understanding cannot be accurately gauged. Customarily the responsibility for resolving these mail order shortfalls is passed to local pharmacies.

Moreover, mail order often has breaks in continuity as a pharmacist in one location confirms a prescription entered into the computer then a second pharmacist at another location verifies the physical medication. In addition, mail order is unable or unwilling to act as patient advocates by providing a short supply when patients run out of refills, contacting prescribers for alternatives when a copay is high or for other reasons, and offering assistance with PAs. Forcing patients to use mail order for maintenance medications will ultimately decrease the local pharmacy options available for patients when they need acute medications or to resolve mail order shortfalls. Finally, mail order is less equipped to detect patient diversion and narcotic prescription abuse.

Real patient medication compliance is best achieved through a personal pharmacist-patient relationship, effective two-way patient counseling, good communication between prescribers and pharmacists, and medication adherence programs. Simply mailing a medication does not ensure it is used as prescribed.

Chronic disease state management is enhanced dramatically by ensuring a local pharmacist is part of the patient health care team. Local pharmacists are able to practice clinical skills, capable to provide compounding services, accessible for provider and patient medication questions, situated to observe signs of uncontrolled disease states like an asthmatic patient regularly buying Bronkaid, and available to prevent harm from interactions with foods and OTC medications. Local pharmacists can physically demonstrate the proper use of an inhaler, point to the line on a syringe for the number of insulin units to be administered, and help a patient learn how to calibrate a glucose meter.

AkPhA strongly supports patient-prescriber-pharmacist relationships, which is why patients should have freedom of choice for their pharmaceutical care.

- Page 9 Part II: Engage employers to improve health plans and employee wellness
 - Section J discusses abuse of prescription opioids

AkPhA commends the commission's focus on the growing problem of prescription opioid abuse as this is of importance to the association as well. AkPhA's 2013 convention provided the followings CEs: Lawful Prescribing and Prevention of Diversion, Institutional Diversion, Medication Assisted Substance Abuse Treatment, and Federal Regulations Update. AkPhA has promoted and supported the DEA Drug Take Back Days, which resulted in the collection of over one ton of medications in two 2013 Alaska events. The association is willing to collaborate with the commission as needed.

E-mail: akphrmcv@alaska.net

- Page 11 and 12 Part II: Engage employers to improve health plans and employee wellness
 - Number 1 Subsection a. discusses establishing an “All-Payer Claims Database”.

AkPhA is requesting to be at the table on all discussions towards creating an APCD. Developing such a database is an immense project with many factors to consider including privacy for patients, providers, and businesses. AkPhA represents a highly diverse group of pharmacists in terms of practice type, location, background, and years of experience. As a result, involving AkPhA would benefit the commission and ultimately patients. The association looks forward to being included on the APCD discussions and planning.

- Number 5 indicated inclusion of the Board of Pharmacy to regulate provider dispensing of prescriptions.

AkPhA supports including the Board of the Pharmacy.

- Number 6 Sub point a. discusses the PDMP being upgraded to real-time and providing support for on-going operation.

AkPhA values the PDMP and strongly supports a real-time upgrade. The association would like to see the Alaska PDMP strive towards integration with other states, especially those in the northwest. Finally, AkPhA would like to know more specifics on the commission’s plan for financially supporting the on-going operation.

- Page 15 Part III: Draft Commission Plans for 2013
 - Section I under Fraud and Abuse Prevention

AkPhA supports the commission’s efforts to prevent fraud and abuse. The association suggests a toll-free number be created specifically for providers, such as pharmacists, to report when they have evidence of patient or provider fraud and/or abuse.

- Section II Continue Study of Current Conditions in Alaska’s Health Care System – The 6th bullet simply says “Pharmacy benefit management”.

AkPhA request for specifics on the commission’s intent regarding “pharmacy benefit management”. If the commission is referring to Pharmacy Benefit Managers (PBMs) this is of great interest to the association. PBMs are dictating much of medication management including limiting prescribers’ choices for medications and directions, squeezing pharmacy reimbursements, offering unrealistic contracts then refusing to negotiate, restricting participation in their networks, creating their own rules for pharmacy audits, forcing patients to use PBM owned mail order pharmacies, setting policy for PAs which generate a profit for the PBM, and so forth.

AkPhA is very interested in discussions on pharmacy benefit management and/or PBMs. The association request to be involved with the commission on this topic.

Thank you for your time and consideration.

Sincerely,

Julie McDonald, Pharm.D.
Alaska Pharmacists Association President

E-mail: akpharmcy@alaska.net

Erickson, Deborah L (HSS)

From: Mayo, Andrew <Andrew.Mayo@uhsinc.com>
Sent: Wednesday, November 27, 2013 5:12 PM
To: Erickson, Deborah L (HSS)
Subject: Comments on the HCC Findings

Dr. Erickson – I know we have met on several occasions and I have appreciated your knowledge and feedback. I also know the Commission has a tough job. I am commenting on transparency for myself and my organization, not as the Chair of ASHNHA. Like my colleagues, I believe in our statement provided and hope to help refine on our ability to be transparent and accountable. My personal concern is that in behavioral health, there are so few providers that our data can be more identifiable. I do have some concerns that in such circumstances this creates some undue legitimate problems not related to data shared in larger groups. One of the goals is to benefit from the data to help guide policy and community needs. I believe part of what led some facilities to want to stop voluntarily reporting was that some hospitals, not participating, received data that allowed them to benefit from the data. In essence, procedures with few providers would result in the same circumstance. I would ask that you consider such issues as you move toward decisions regarding what we are asked to provide, who has access and how it is used. Thanks for your consideration of my concern.

Dr. Andy Mayo, CEO
North Star Behavioral Health
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andrew.mayo@uhsinc.com

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Erickson, Deborah L (HSS)

From: Burrell, Pauline M <P.Burrell@MSrhc.com>
Sent: Wednesday, November 27, 2013 5:47 PM
To: Erickson, Deborah L (HSS)
Cc: Lee, John R.; Gordon, Misty D
Subject: Transforming Health Care in Alaska
Attachments: Alaska HC Mat-Su 11-13.pdf

Deborah,

I have attached my comments for the commission to review regarding the strategic plan for *Transforming Health Care in Alaska*.

Have a good day,

Pauline

Pauline Burrell RN, BSN | Chief Quality Officer | Case Management | Mat-Su Regional Medical Center |
2500 S. Woodworth Loop | P.O. Box 1687 | Palmer, Alaska 99645 | Phone: (907) 861-6661 | E-Mail:
p.burrell@msrhc.com

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November 27, 2013



Deborah Erickson
Alaska Health Care Commission
3601 C Street, Ste. 902
Anchorage, AK 99503-5923

Regarding: Transforming Health Care in Alaska

Dear Deborah Erickson:

I am Pauline Burrell, Chief Quality Officer and Director of Case Management at Mat-Su Regional Medical Center, in Palmer, Alaska.

The Case Management Department at Mat-Su Regional Medical Center is tasked with developing a safe discharge plan for all our patients. Case Management is staffed by four social workers and seven registered nurses. We work 12 hour shifts, 7 days a week focusing on safe and appropriate placement for patients in/near their home community.

We are in desperate need of a nursing home in order for residents of the Mat-Su Burrough to remain close to family and support networks in their own community. Anchorage currently has two nursing homes which are located close to but still outside this community. These nursing homes have a minimum of a 6 week wait for admissions. Currently we are required to place people outside of their home community in places such as Homer and Seward. Support networks and family ties are threatened by the great distances between our patients and their families.

In 2012 we were only able to place 15 patients in a nursing home, all outside their home community. Thus far in 2013 we have only been able to secure placement for 8 patients, again outside their support network / communities.

Mat-Su Regional Medical Center is licensed for 4 Swing Beds that are continuously full with a waiting list of patients waiting for those patients to be placed. In 2012 we placed 81 patients in these beds and we are projecting 72 swing bed patients in 2013. The number of patients is dependent on the length of a patient's stay while awaiting long term placement. The optimum placement is in a facility within the home community where our patients can maintain support and care networks.

Without a nursing home in our community, we have maximized our ability to place patients in Assisted Living Facilities (ALFs) in our area. Even using ALFs we must place people outside of their home community and support network due to the lack on ALF bed availability. In 2012, we placed 104 patients into ALFs and are projected to place 152 patients by the end of 2013. Due to the lack of skilled nursing facility beds and limited options in our community, we place complex patients into these ALFs when a skilled nursing care would provide better support for their medical needs.



Only a few ALFs in our community will take hospice patients. In order for patients to have hospice in their home, they require 24 hour care. There is no hospice facility in or near this community. The Hospice referrals have decreased from 61 in 2012 to 36 projected in 2013 potentially due to the lack of resources. Many people move to Alaska at retirement age and leave their families in the lower 48. These patients could have hospice in a skilled nursing facility, if one were available.

Physicians order home health for patients who are home bound. Due to the large number of patients discharged home or to Assisted Living Facilities, at times we have maximized the capabilities of home health agencies within our community.

Mat-Su Regional Medical Center is a community hospital whose primary concern is the well-being of our community. Please make the care of this vulnerable population a priority within your strategic plan.

Thank you for your consideration of the issues our seniors and vulnerable population's needs. Please contact me with any questions. Email me at p.burrell@msrhc.com or call my office at (907) 861-6661.

Sincerely,

A handwritten signature in black ink that reads "Pauline Burrell". The signature is written in a cursive style with a large, prominent "P" and "B".

Pauline Burrell, RN, BSN
Chief Quality Officer/Director Case Management
Mat-Su Regional Medical Center