ALASKA HEALTH CARE COMMISSION

TRANSCRIPT OF PROCEEDINGS

March 21, 2014
Alaska Office Building
350 Main Street, Room 115
Juneau, Alaska

and

March 22, 2014
State Capitol Building
120 4th Street, Room 106
Juneau, Alaska

ROSTER

Commission Members Present:
Ward Hurlburt, M.D., M.P.H., Chair
Valerie Davidson (telephonic)
C. Keith Campbell
Jeffrey Davis
Emily Ennis
Allen Hippler
David Morgan

Commission Members Absent:
Lawrence Stinson, M.D.
Robert Urata, M.D.

Ex Officio Members:
Jim Puckett
Representative Wes Keller
Senator John Coghill

Executive Director, Deb Erickson
Barb Hendrix, Administrative Assistant II

Others Present March 21, 2014:
Rynnieva Moss, Senator Coghill's Office
Kathy Craft, AHWC, VA OHPD
Mark Foster, ISER
Becky Hultberg, ASHNHA
Tom Studler, Representative Higgins' Office
Marie Darlin, AARP
Misty Hester, Division of Insurance
Lori Wing-Heier, Director, Division of Insurance
Lorilyn Swanson, Senior Advocate, State Medical Advisory Committee
Margaret Brodie, Director, Division of Health Care Services, Medicaid
Lydia Bartholomew, M.D., AETNA
Emily Ricci, Governor's Office
Alex Malter, M.D., DHSS/Medicaid
Pat Jackson, ANTHC
Representative Paul Seaton, Alaska State Legislature
Michael Monagle, Director, Division of Workers Compensation
Michael Barnhill, Deputy Commissioner, Department of Administration
Mary Graham, retired public employee
Wayne Stevens, United Way of Southeast Alaska

Others Present March 22, 2014:
Kathy Craft, AHWC, VA OHPD
Becky Hultberg, ASHNHA
Lydia Bartholomew, M.D., AETNA
Emily Ricci, Governor's Office
Janet Ogan, Representative Keller's Office

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FRIDAY, MARCH 21, 2014
8:00 A.M.

WELCOME AND INTRODUCTIONS

CHAIRMAN HURLBURT: Can we go ahead and get started? I'd like to welcome everybody here for the Health Care Commission meeting. This will be a little different than our other meetings have been. We are at a juncture which -- as everybody knows, the commission has come to its sunset time based on the law establishing the commission. And the legislative audit folks have looked at it and made a recommendation to continue the commission. It's their perception that it's of value to the legislature and, I guess by extension, the governor's office.

So we'll be talking some today. We won't know until it's done whether the law does pass to extend the commission and the governor signs it. But I think we'll be operating on an assumption that that will be the case as we talk about where we'll go going forward.

You all received the meeting notebook. I know Jeff was out of town and didn't

get it until now, and you had the assignments in there. Deb did really an outstanding job putting this together. And if you have not had a chance to look through it and read it, particularly some of the lists that are in there of the activities that are going on in various areas, I would recommend that you do that when you're able. And I think that it will be helpful.

The commission has been charged right from the beginning with looking at issues of access, of quality and affordability of care, of appropriateness and so on. And we've spent the vast majority of our time talking about the cost issues, as it's a national challenge and even more an Alaska challenge.

And we've also focused on reflecting, I think, what the vast majority of us have sincerely felt is the way we need to approach it, looking at market-based solutions to the reality that 21 percent of Alaska's gross domestic product is going for health care within the context that we can control that and really see that come down over time along with enhancing quality of care.

But the context that we've talked

about is a market-based solution with leadership being provided by providers who -- we all understand the ethical and moral dimensions, to use a phrase I've used before, of this industry. It is an industry. It is a business, but there are those unique aspects to it. But I think that providers -- whether it's physicians, hospital administrators, or others -- are uniquely in a position to lead that; but the reality is, by the way we were all created, that it is going to take some outside pressure to change that.

And the risk is -- and I think it will be clear in a minute why I'm going through all of this again -- the risk is that we'll see other kinds of solutions coming.

For example, this was an article coming from that well-known newspaper source Al Jazeera. But it was talking about what is happening in the state of Maryland, for example. And now the government in the state of Maryland has a system where they basically determine what hospitals are going to receive for whatever happens. And this comment in here says, under the new plan, all the state's hospitals would get an annual budget based on what they charged the

previous year and would have to limit its total fees to that amount. All patients at each hospital would pay the same for each service.

And we know it's getting closer to a single-payer kind of situation. We know Vermont is moving toward that. And those are not necessarily evil or bad solutions, but I don't think that they're the best American kind of solutions.

Now, we've talked about the second most costly countries for health care, Norway and Switzerland. If, over the last 20 years, we had spent what they spent, which is about two-thirds of what we spent, we would have saved $15 trillion in the U.S., and they live longer and their babies die less than ours. But their solutions are not our solutions.

The last comment in this vein -- this was another interesting article, and I've got three or four copies if anybody wants to look at these. They're not necessarily worth your time. This was an interesting article from the Harvard Business Review, but, strangely, talking about what's happening in India, where the health care conditions are much worse and where still the

majority of people don't get health care, but where the middle class is growing and the country is prospering more, but their resources are far more limited than ours. But this is a real market-based solution of what's happening in India in putting up centers of excellence and developing regionalized systems of relationships there.

And they're using what they can charge the more affluent people or medical tourists, where they're being charged maybe 10 percent, 25 percent of what we pay in this country, but using those charges to help offset services they are providing to the more needy. But it's all being done in a market-based fashion.

And what particularly interested me is, coming toward the end of it, one of these companies that's doing that and prospering in India is recognizing that, while people intellectually may see a medical tour is maybe a good thing but "I'm not sure I want to go to Bangkok," or "I'm not sure I want to go somewhere. Do they really know what they're doing, even if they've been trained in the U.S.?" They are putting up a 2,000-bed hospital -- that's a big hospital, a 2,000-bed hospital -- on Grand Cayman to try to attract

Americans there. A lot of Americans, like myself, have been to Grand Cayman to go scuba diving, and we think of it as an offshore banking haven. But again, I'm saying that there are market-oriented, business-oriented solutions looking at improving quality, helping control costs. And I think that's a part of the vision that we have here.

The last thing in that vein that I want to say is, because each year from 2010 on, January 2010 on, we have made our recommendations to the governor, to the legislature, and continue to do that; but there are changes that will require -- recommendations that will require changes in what we do, such as legislative changes.

And without embarrassing him, I would like to personally acknowledge what Commissioner Representative Wes Keller has been doing in the legislature this year, sponsoring several pieces of legislation that are really looking at the recommendations, taking very seriously the recommendations that we've come up with as a group. Whether they will succeed this year or not, we'll see. There are lots of crossed fingers. But each one of those will engender opposition from folks who will have to change.

There are folks that need to change -- those on the provider side need to change. We need to do that, but those are the folks that need to provide the leadership to try to retain the kind of health care system that we want and need to have in our country for Alaskans and for Americans with the kind of quality, the kind of compassion that we have. And I would just publicly like to thank Representative Keller for his courageousness and his understanding and what he's doing there.

So that's kind of the lead, and we will be having much more of an open discussion today as soon as we finish this initial welcome. Commissioner Streur is going to join us at the table and will have some things to say, perhaps, but mostly to become a part of us as we look at the issues that we'll get into there.

COMMISSION MEMBER AND GUEST INTRODUCTIONS

CHAIRMAN HURLBURT: Now, we'll start out now and go around the table and have everybody introduce themselves and then the public members that are here as well and then move into the agenda.

So, Jim, can you start?
MR. PUCKETT: Jim Puckett, representing the Office of the Governor and all Alaskans.
MR. DAVIS: Jeff Davis, representing payers and all Alaskans.
MS. ENNIS: Emily Ennis, representing the Alaska Mental Health Trust Authority.
MR. CAMPBELL: Keith Campbell. I'm the consumer representative on the commission.
MR. HIPPLER: Allen Hippler, Chamber of Commerce.
MR. KELLER: Representative Keller, liaison to the House. And I want to say that Senator Coghill will be in a little later.
MR. MORGAN: Dave Morgan, occupying the seat for the representative community health centers.
MS. ERICKSON: And Lynda?
CHAIRMAN HURLBURT: Keep us going, so you need to introduce yourself.
MS. BARKER: Thank you. Lynda Barker, court reporter.
MS. ERICKSON: Deb Erickson,

Executive Director of the Health Care Commission.

CHAIRMAN HURLBURT: And I'm Ward Hurlburt, chair of the commission and chief medical officer for the state.

Barb, can you introduce yourself?

MS. HENDRIX: I'm Barb Hendrix, administrative assistant.

MS. MOSS: Rynnieva Moss, Senator Coghill's Office.

MS. JACKSON: Pat Jackson, ANTHC.

DR. BARTHOLOMEW: Lydia Bartholomew, senior medical director for Aetna.

MS. DARLIN: Marie Darlin, representing the AARP.

MS. SWANSON: Lorilyn Swanson, senior advocate.

MS. GRAHAM: Mary Graham, retired public employee, a person in the public interested in health care reform.

MS. HULTBERG: Becky Hultberg, State Hospital Association.

MS. RICCI: I'm Emily Ricci, Office of the Governor.

MR. STEVENS: Wayne Stevens, United Way of Southeast Alaska.

MS. ERICKSON: And we need to recognize Wayne. He's a charter member of the commission and alumni of the commission, formerly in the Chamber of Commerce seat. Thanks for being here, Wayne.

MR. STEVENS: Thank you very much. I was trying to stay out of it. (Laughter.)

MS. CRAFT: I'm Kathy Craft with the Alaska Health Workforce Coalition.

DR. MALTER: Alex Malter, Medicaid medical director.

MS. BRODIE: Margaret Brodie, Health Care Services.

CHAIRMAN HURLBURT: And Wayne was saying, when he left the Health Care Commission, he took a little time off before he went back to work, and he went skiing. So those of us on the commission, I think we should plan -- when and if we ever leave the commission, we'll follow in Wayne's footsteps. You've bushwhacked a good trail for us doing that, Wayne.

And we welcome everybody here. We appreciate you being here.

2014-2017 CONTEXT:
THE COMMISSION'S NEXT THREE YEARS

CHAIRMAN HURLBURT: So as we move into the agenda now, we want to talk in the context of the next three years. It's not cast in concrete yet, but personally I'm optimistic that if we are of value -- my comments to the members of the legislature are that if we are of value to you -- and my bias is that we have certain value in our function -- that we should be continued. But if not, if we're not of value, then we likewise should not be continued, and requesting that they make the decision in that light.

One of the questions I've been asked is: Should we extend it for longer? I think one of the members of the legislature said like eight years. And my response was that I felt that the legislative audit process was very helpful. It certainly was to Deb and to me and I think all of us. And I would want the legislature to periodically look at what we're doing.

So my suggestion was, however the language is, that the three-year time frame -- again, to look at what we're doing. Is it of value

to the governor's office? Is it of value to the state, the people of Alaska? Then it would be appropriate to do. But we know that neither today nor three years from now will all the issues be resolved. It will be a long process to bring about the changes that we want and we need to have.

So we want to talk about the context of the next three years. One of the criticisms and suggestions that folks in legislative audit had was that we had not engaged enough in developing a formal health plan for the state. And so Commissioner Streur has embraced that, and the structure would be that the Health Care Commission would be a resource but that the plan would really be developed within the Department of Health and Social Services; but we would have a big role to play.

A lot of what we've done, a lot of the reports that have been generated, a lot of the information, a lot of the recommendations really would lead into that now, but the leadership would be there. So we want to talk some about the facilitation of developing of the plan. I think we'll all be interested to just have a little update and then some discussion. The Medicaid

Reform Advisory Committee, which Commissioner Streur chairs and which was just appointed last week there. And a little bit about where we are with the Affordable Care Act, perhaps.

I was just telling Jim, you know, we all read the news, that there continues to be challenges around the country, and we've had some challenges related to the transition from HealthSmart to Aetna with our contract here, but that's always going to happen. And to get some long wait times. And what I read was, with the exchange in California, where they have had the state-operated exchange, that fully half of their phone calls have been abandoned, that the access has been so good.

And our wait times got out a little far, both with DRB and Aetna at times here; and they are back down now, but nothing like what's happening in California. So we were -- Jim and many others really worked hard, and with his colleagues, and Aetna did to get the service levels back down to what they ought to be. But they weren't nearly that bad. So we'll talk a little about where things stand now.

Commissioner Streur, I don't know

if you want to start out with any comments.

COMMISSIONER STREUR: I will, Ward.

Thank you all for letting me be here today. I'm so used to testifying lately, it seems that I want to begin by saying, "For the record, my name is." So I'll say it. For the record, my name is Bill Streur. I'm the commissioner of the Department of Health and Social Services.

As Ward has been talking, I've been kind of reflecting a little bit about where we've come and where we have to go, because we've come a long way, but it's kind of like you're taking a trip cross-country. And the first day, you put in 400 miles, and you have another 2,000 to go. But you are feeling pretty good about where you've come, and then you start looking at what's left on the trip. That, to me, is where the department is, and it's where health care is in Alaska. We have so much opportunity. I get tired just thinking about all the opportunity that we have.

This is my fourth session as Commissioner, and Representative Keller and I were just reminiscing a little bit before about the

challenges that are before us and how it's a brave new world that we're facing. Not trying to steal from Aldous Huxley, but it is a different world; and we're going to have to be brave. But it's a new world, and there is lots of opportunity there.

Ward has talked about Norway and other countries and what they have done and what their health care is and what our health care has become. And I look at that, and I look at the department and what we're doing. And we have moved almost the entire department to results-based budgeting, results-based accountability -- whichever you want to call it -- and beginning to measure the outputs and the outcomes of what we do.

And I think the entire industry has to begin doing that, whether it be ASHNHA, whether it be the nursing homes, whether it be other providers out there, whether it be our physicians and our specialists. We can't continue to do what we're doing. The department can't continue to do what we're doing.

We had several increments that disappeared off our budget this year. We've been able to move some of those and get some of those back on but at the expense of other areas. And for

me, it's an awakening that, even though we have done a lot of the state -- we've been 2 percent, 1 percent, and one tenth of 1 percent in terms of budget growth. When you look at Medicaid, that's a pretty significant slowing of the growth in the state. And yet, when I go to the legislature, it's more. We've got to do better. And the only way that we can do better is to begin to measure and to be accountable to this.

And that's with everybody at the table. As you were going around and introducing yourselves, I purposely avoided that, because I wanted to surprise everybody with who I was -- no. (Laughter.)

But as you go around the table, it's about having people at the table. It's about people saying, "Okay. It isn't about my ox, it's about our ox." And we're not out to gore an ox; we're out to roast an ox. And we've got to get together on this stuff.

Becky and I worked together for a couple of years before she deserted us and went over to the dark side, as we call it. But she and I were working toward, you know, what can we do in the state, because it's a state issue, whether it

be employees, whether it be Medicaid. We've got to do better. We can do better, and we've got to all be rowing in the same direction.

And that's why I kind of welcomed the review that was done on us, and it said that we need to do more. The Health Care Commission and the department need to be rowing in the same direction. We need to be in the same boat. We need to be pushing in the same direction, because the legislative process and health care is only as good as the information that we provide to you.

You can slash and burn. That's a phrase I used in House Finance this year. You can slash and burn, but people are going to be damaged. You've heard me say this. Health care is a balloon, and if you push it in one place, it's going to bulge in another place.

And we've got an aging state. Look around the room. There are a few younger ones here, but --

CHAIRMAN HURLBURT: Hey.

(Laughter.)

COMMISSIONER STREUR: But it is an aging state. Our growth -- last night I heard that our growth is four times the national average, yet

we grew by 70 percent in the last census, and nationally we grew by 14 percent in terms of senior citizens 60 and above. And that's a five times growth. Either way, it's significant growth, and Alaska is going to have to change the way we deliver health care.

So after saying all that, Dr. Hurlburt, Deb, members of the committee, I accept the challenge, and I look forward to working with you in making this happen. And that's a speech to the group out there too. It's -- everybody needs to be there. It's about being brave. It's about being bold. It's about challenging. And one thing I'm not often accused of is shirking a challenge, so it's -- we need to begin it now.

The Medicaid Reform Advisory Group -- Emily is sitting there, Emily Ricci, I don't know if any of you have met her. She's working in the governor's office on health care issues. She's going to be knee-deep in the Medicaid Reform Advisory Group, whether she wants or not. I'm going to make sure of that.

But all of you, too, I encourage you, as you have opportunity -- we'll have monthly

meetings. I think the first one is going to be late April, and they're going to be at least all-day meetings. And it's going to be about looking at best practices. It's going to be looking at brighter, smarter, wiser ways to do things; and everything has to be on the table.

But in this state, Medicaid and health care have to go together. And, so, Jeff, I expect that Premera will be there, as with other insurers, to join with us in what we're doing to make sure that we develop a system that is not a one-size-fits-all but is a system that can reach out to all and serve all. So stay tuned on that one.

The gap analysis is proving to be a bit more formidable than one would think. We ought to be able to identify those people that don't have any insurance, that don't have any access to any insurance. But when I look at the millions and millions and millions of dollars that are expended in this state in health care, there's got to be enough.

If I take and I calculate everything that's there and divide it by the population, I come close to $11,000 per citizen in

the state of Alaska per year that's available in health care to them, based on what we spend. That's a lot. Commercial insurance is around $5,500 a year, I believe, the last time I looked. In the Lower 48, it's around $4,400 a year. And we have $11,000 per citizen up here.

And identifying where those folks are that don't have access, that can't get their diabetes care, that can't get their medicines, that can't get the specialist visit is proving challenging; and we continue to work at it. We continue -- Emily developed a matrix that I think is promising, and we need to begin to figure out how to fill it in, how to fill it in to operate from, and what those folks look like.

So there's lots of opportunity -- lots of challenges and lots of opportunity. So I will stop with that and say: How are we going to work together? So . . .

CHAIRMAN HURLBURT: Thank you, Commissioner Streur.

In thinking about the development as we look at the health plan first, and the development of a health plan with us sponsoring a number of the analyses, developing the information,

developing some fairly clear and specific recommendations that go into that, do any of us have any questions for Commissioner Streur as to how the process would work, coming to a health plan, and would the health plan be, and how could we collectively all assure that a health plan is more than a document that costs a lot of people's time and effort and then becomes a book on a shelf that someday may find a space in the Alaska State Museum as a relic of interest? But how can we make sure that, as we do that, it's something that can have a positive impact on our health care system in the state? So, any questions for Bill on that?

MS. ERICKSON: Or does he have any questions for us?

MR. HIPPLER: I have a question, Mr. Chairman.

CHAIRMAN HURLBURT: Yes.

MR. HIPPLER: Commissioner, the health care plan -- will it be segmented into the state health care plan for employees and retired people and Medicaid and the general population? How do you deal with those different segments of the population in the state?

COMMISSIONER STREUR: I believe it

shouldn't be separate. I believe we need to look at -- as I've said, not one-size-fits-all, but a delivery model that reaches the most people in the most effective manner at the lowest possible cost.

And the access shouldn't be regulated by payer; the access should be regulated by need. And we have to get to that point, because -- and I'm going to use Premera, since Jeff is sitting at the table. The delivery model that we pay for in Medicaid shouldn't be remarkably different than the delivery model that Jeff is providing at Premera. We should have a similar prevention focus. We should have a similar access-to-specialist focus.

I even heard about standard release forms, standard information forms. You know, we're soon going to have an information system that's electronic, electronic records -- excuse me -- health care records from one entity to another, and so there should be increasing similarity in what we do.

But to answer your question, I do not believe we should segment by payer. And maybe Jeff has got a different perspective on that. But you're scowling, so --

MR. HIPPLER: No, I didn't mean to scowl. I was thinking.
COMMISSIONER STREUR: Oh, okay.
MR. HIPPLER: Sometimes that's uncomfortable.
(Laughter.)
MR. CAMPBELL: How much resistance are you getting from the recommendations you've tried to implement?
COMMISSIONER STREUR: I'm sorry?
MR. CAMPBELL: How much resistance are you receiving from effective entities that are trying to implement some of the recommendations we've made to you over the last two or three years?
COMMISSIONER STREUR: It changes, Keith. It's from entity to entity. There's -- nobody wants to lose money in the way that care is delivered. Everybody wants to be paid more, and the money is not there.
The resistance is usually coming from an emotional bent more than a business bent. If I were to freeze rates across the board for one year, I would probably save in excess of my increment of increase that I have in the Medicaid budget; but the hue and cry from many groups would

just be something that people like Representative Keller do not even want to think about.

In the budgeting process, you see it every year. We had some minor increments that were -- I say minor increments in terms of dollar amounts. And remember, this is in the context of a $2.67 billion budget. An increment that, you know, reduced the budget by $1.2 million. Another one by a million dollars. What came out of the House was about $6.5 million in cuts. That's not bad. And yet the hue and cry that came from that was just overwhelming.

And so the resistance -- it varies a lot, but we've got to figure out a way to meet our duty to Alaskans by doing it in a fiscally conservative and reasonable manner. Our PCA waiver programs are growing by in excess of 10 percent per year. My Medicaid increment -- $15 million of my $18 million Medicaid increment was for waivers, and that's not sustainable.

CHAIRMAN HURLBURT: Yes, Dave?

MR. MORGAN: I think what you're talking about or trying to get to is -- I have two examples. One is the collaboration and virtual merger to deliver the same services by the VA tribes

and community health centers, the four entities going together to offer services, whether it's in False Pass, population 98, or in Anchorage, in the Anchorage Neighborhood Health Center, which isn't tribal, which signed a contract last week to basically accept 2,000 overflow veterans that can't get access to care in Anchorage.

But what I ran up to -- I serve on the municipal -- was a long-year pitched battle virtually just to change one bus route so people could get to the community health center, which did happen or is about to happen between the Health Commission and the Advisory Transportation Board.

It just seems like that contract with working with VA, the tribes, community health centers and that process, and just what I've experienced as a volunteer trying to get a bus route changed by .6 of a mile and 8 minutes in a route, it just seems like a Herculean activity just to get that done.

The hope I saw was, though it took several years, was that merger or collaboration with the VA, tribes, and all the community health centers, which is, at least in travel and some other things, is reducing expenditures that you put

all three systems together.

Is that sort of what you're thinking, of providing access but also taking -- you know, it's like the old Eagle Scout thing. You inventory what you got and then apply it in different formats in order to meet that objective of providing the services at the right place, right time, and at the right price that you talk about. Is that what we're talking about?

COMMISSIONER STREUR: It is, David. Maximizing and pointing the resources at people -- yes, pointing resources at people. We knew that we had lots of veterans out in rural communities. We know we have lots of veterans in urban communities, and nobody was pointing services at them. And so they were wandering around trying to find the service. And I'm going to pretend I'm a service. Everybody was going like this (indicating), looking away, rather than looking at them and inviting them in.

The VA contracting with TriWest, who was the TRICARE contractor in the West for a few years -- VA is now contracting with them. And they literally have moved mountains in terms of ensuring that access, increasing that access by

simply setting up a payment vehicle. The money was there. The resources were there. The people were there. It was a matter of bringing them all together.

Does that answer your question?

MR. MORGAN: Yes.

COMMISSIONER STREUR: Okay.

CHAIRMAN HURLBURT: Emily?

MS. ENNIS: Commissioner, you mentioned the unprecedented growth in our senior population. How will our state plan to address the needs of seniors, both their growing medical needs as they age and their long-term care needs? And also, could you perhaps talk about how we will create that universal access across both the medical arenas in our state as well as urban/rural?

COMMISSIONER STREUR: It's important, and the big reason for that is, there is nothing more dynamic in our lives than the changing health care environment, whether it be the increasing need -- I dare to bet you that, in 2008, none of us expected to see that the senior population was really growing by 70 percent in a decade, and yet it has.

The other variables -- the array

of services available, the array of services that are paid for, the development of waiver programs. I think where plans fall down is, we treat a plan as an event, not as a part of a process. And so we do this great and wonderful plan, and we put it on a shelf. I have so many plans in my office in Anchorage that I finally -- the other day I said, "I've got to get these out of here. There's just too many of them."

I don't know how many plans SDS has done, but it seems that it's the plan of the biennium. And the planning process has to be continual tweaking. Every year it needs to come out and say, "Okay. How does this fit? What should we be doing?" And we don't do it.

And so we do the plan, and we put it on the shelf. And much of what we do in the department -- and I'm going to speak for the department -- we just keep doing what we've been doing. And we come to the legislature, and we say, "We need more money to do what we're doing," and we may be missing the mark with what you as providers really feel is impactful. And we need to be working more closely with our -- we need to be working more closely with the entire provider

community, and we haven't done that.

And on the other side of it is, you guys don't push back enough. And it's not about yelling and screaming and stomping your feet; it's about saying, "Commissioner, you need to look at this. Duane, you need to look at this, and we think this is the direction that we need to go. We'd like to be a part of making that happen." That's what it's going to take, not creating a plan and putting it on a shelf.

So I'm a legend in my disdain for plans, so -- sorry for saying it that way, but . . .

MS. ENNIS: Thank you.

CHAIRMAN HURLBURT: Commissioner Keller?

MR. KELLER: I'm going to step out in a few minutes, but I really appreciate the conversation. And I also really appreciate Dr. Hurlburt and Dr. Streur.

I just wanted to -- there's something that hasn't been said on the record. The cuts, the tightening, whatever we're facing here is very real, and it's not something that the legislature, because of a political persuasion, has

decided just not to spend the money. That's not what it's about. You should have -- I wish you could have seen the response when we got the briefing on the projected revenue for the future, you know, over the next 10, 15 years. It was a pretty quiet session as we realized, you know, what could be ahead of us.

And it would be very foolish of us not to, as a commission -- and by the way, I appreciate all of you. I appreciate this commission, and I've really enjoyed working with you. I think we have a huge opportunity and an incredible challenge ahead of us on this whole thing, but we have to do it, because, you know, like Dr. Hurlburt pointed out, the consequences of decisions at the policy level hurt people bad, kill people. And it's huge.

But if we do not look at this projection and take it seriously and begin now, there will be a whole lot of people hurt down the road if there's a crash. And we just have to get this -- do the best we can, you know. And that means, like you said, roasting the ox together. All of us have to take some hits on this.

Anyway, I just wanted to say that

for context because, on the record so far, you know, in talking about the challenges we have ahead of us, they're pretty sobering. And I guess I want to say it's real. It's not projections we're making; it's projections we're trying to respond to. So . . .

CHAIRMAN HURLBURT: Thank you.

MS. ERICKSON: Can I ask Representative Keller a question and put him on the spot, since he's going to have to leave?

And we'll continue this conversation later when you and Senator Coghill both are able to be back with us.

But I think, throughout the next day and a half, we'll be having a conversation and try to feel our way along about, assuming the commission is continued for another three years, how might our role evolve.

And a significant question is: What are the needs and expectations from the legislature, since we really are charged with providing recommendations about state policy to the legislature and to the governor? And at this point, I believe this commission has done a really good job in laying out a pretty solid set of core

strategies and policy recommendations around those for improving cost and quality of medical services.

Is there something more where -- especially where we have recommendations that are -- would require state legislative action to change, is there something -- I'm getting more and more questions from legislators who are starting to pay attention to those, so it's something we'll talk about throughout the day today and have some examples of so we can start digging in and saying: Is this something the commission can actually do, or is it too far in the weeds or not an appropriate role?

Do legislators need something more from the commission, rather than a sentence or a short paragraph about what's needed in terms of legislation? Is there more needed in terms of principles or even example draft legislation?

So if you feel comfortable answering that question now, or if you could be thinking about it throughout the day, we can continue the conversation throughout the next day and a half.

MR. KELLER: You know the saying, "Fools rush in." Well, I would rather give that

question -- it's a very good question -- some thought; but I do want to give my knee-jerk response, because sometimes that is the most valuable.

And that is that we, as legislators over there, often get taken by surprise on the politics that are tied in under the surface that we can't see in the health care field. And if we, as a commission, could throw some sunshine on some of that stuff, you know, it's pretty tough. It's pretty tough.

We are all here representing an advocacy group, you know, that we have interest in; but to get something real straightforward and throw sunshine on some of the dynamics behind the scenes without getting into specifics -- you know, maybe I shouldn't say that, but I just recently was shocked at a reaction that I did not anticipate. And you'd think I'd know, you know. I've been around a little while.

But that kind of thing, you know, getting some sunshine on the dynamics that are happening. There is a lot of interest there. Why not be right up front with them and put it on the table?

And just in that light, I'd like to compliment Jeff. You've done a real good job with the insurance industry. Thank you.

MR. DAVIS: Thank you, Representative Keller.

MR. KELLER: But if I could continue that after I converse with my compadre, Senator John Coghill, I would love that later in the process.

MR. DAVIS: So I have sort of a practical question here. When I think about a statewide health plan, that's daunting to me; and a lot of what we've talked about in health care in general is daunting. But how far has the thinking gone in thinking through just the practical reality of how we'd go about doing that? Have we gotten there, or have we just articulated the need to do so? Where are we? I'm just trying to get my brain around how that would work.

MS. ERICKSON: One of the things I want to clarify -- it might be clear to folks around the table, but it might not be clear to the public. Folks get confused when we refer to a health plan. And some people, as we've talked about that, have assumed we're talking about a health insurance plan.

And that is not what we're talking about, if anybody in the room was confused about that.

What the authorizing legislation for the commission -- and I've included a copy of that behind Tab 1, so you have it handy if you want to reference it. It actually, in addition to creating a new section that created the commission, it added a duty for the Department of Health and Social Services under the department's duties to -- it really isn't a mandate. It's a "may," not a "shall" language -- that the department may develop a plan based on the recommendations of the commission. And the commission's charge was to foster the development of a state health plan.

And so we had a number of conversations with the auditors about what the word "foster" means, what a state health plan would look like. I suggested to them early on that providing a vision and a set of core strategies and a series of policy recommendations and engaging in conversations like we have all along with the department was an appropriate -- at least a good start for providing a framework for a plan and fostering a plan.

And in the end, after a couple of

months of struggle and study by the auditors, they decided that what they needed to see more was an actual action plan, laying out who is going to be responsible for doing what by when to implement the recommendations of the commission, and understanding the commission has no authority to tell anybody what they're going to do by when.

What I would do right now is point you to behind Tab 2 on your notebook, and it -- in your notebooks. And this is -- for folks online, and there is not a copy of this in the room, but it's part of the commission's -- it's one of the appendices in the commission's 2013 annual report. So this is something we've looked at before but we haven't really spent any time talking about, and I haven't updated it since we included it in the 2013 report. But based on the recommendations of the commission, what we started doing -- Ward and I started meeting with some of the key division directors, not just in the Department of Health and Social Services.

So the folks who are going to join us at the end of the table for the last half of the morning this morning -- so, for example, Margaret Brodie, who is the director of the Division of

Health Care Services here and responsible for administering the state's Medicaid program, just as one example. Meeting with representatives from the Department of Administration, the folks who are responsible for administering the state employee and retiree health plan, as another example. Mike Monagle, the director of the Division of Workers' Comp, since we have recommendations specific to the Workers' Comp program.

And we started documenting -- we put together this template in this document that's just a preliminary draft. We called it a strawman. What we have in the end might not look anything like this at all, but we wanted something tangible that we could start using as a tool, anyway, for documenting what are those things that these different agencies -- the state Medicaid program, the state employee retiree plan, workers' comp -- the major programs that are responsible for paying for or regulating health care in this state, what are they doing now already that aligns with the commission's recommendations, and what are those things that they are planning to do in the not-too-distant future or would like to do but might not have the resources or the regulatory and

legislative support or whatever other barriers they might face, what are the things that they feel like they need to do?

So we started those conversations initially, just Ward and I meeting individually with these different division directors. We're starting to bring them to the table more. We had former Commissioner Hultberg, Mike Monagle, just as a couple of examples, at our last meeting.

And so this is something that I'd like you to look at throughout the day, if you haven't had a chance to do your homework with your notebooks before this meeting, to be thinking about if this is what you would imagine as a state health plan, if you look at the framework we are putting together here, just starting off with a very brief list and description -- very brief description -- and general timeline for initiatives the different agencies are working on.

And then our plan beyond that, there is a form -- there are a couple of things in the back of this document, the last couple pages of this document. One of the things that we did was take a stab at kind of identifying the roles of different state agencies related to health and

health care, and we have categorized that. Again, if you're looking at this Transforming Health Care in Alaska state agency plan document, the very -- the last -- second- and third-to-the-last pages, and it's laid out landscape. And the title of that section is "State of Alaska Agency Roles in Health and Health Care."

CHAIRMAN HURLBURT: Pages 20 and 21.

MS. ERICKSON: Thank you.

And we've identified three different categories, three different general roles, and the first being agencies that are responsible for either purchasing or regulating medical and/or behavioral health services. The second category -- the second role is a role in protecting or promoting -- so we call that first role "Purchase and/or Regulate." The second one is "Protect and/or Promote," so agencies that are responsible for services or activities or measuring or planning intended to improve or protect health. And then a secondary role related to health are agencies whose actions impact health but not as a primary mission.

And again, this is still a draft

and just based on some preliminary studies of what the different -- just going down to the division level within each department, identifying those divisions that have either a purchase/regulate role, a protect/promote role, or some sort of secondary role. So these might not even be categorized -- and we've listed every single state agency, and the only agencies where we've listed divisions separately are those that have a primary or secondary role, a purchase/regulate or protect/promote role.

So part of the process -- and I didn't include it in your notebooks, but we've included in the past -- the commissioner was referring to the shelves of plans and reports he has. We have inventoried the plans and reports going back ten years and are trying to keep that up to date and have links to all the different documents. And it's an Excel spreadsheet that is pages and pages and pages long. And so we have that available on our website as well, and we're looking to that to understand what these different divisions' and different state agencies' roles are.

So using that as a starting point, and then having -- starting these conversations, we

thought if we could just inventory those initiatives of the agencies that align with the commission's recommendations as a starting point; and once the leadership in those agencies are comfortable with that list, then we'll ask them to fill out, on the very back page, page 22, the state agency action plan template that would just be one, hopefully not more than two, pages, to, at a very high level, try to capture the major action steps and milestones and outcome matrix for each of those initiatives.

And that the commission would, over time -- again, it's not the commission developing this plan. We're doing a lot of work, of the busywork, of some of the research and typing and meeting and compiling; but it's really the agencies providing -- the agencies who are responsible for these different programs and that have the authority and the resources to actually implement these changes are the ones bringing these actions and these plans to the table, and that the commission would be a forum for convening conversation.

I think one of the things that I have never experienced before in my going on 30

years in state government now, that the commissioner was referencing earlier a little bit, is that just starting these conversations across these agencies has really started building some bridges.

And the fact that we'll have these division directors from different departments within state government -- now, if you go to -- I don't want to go off too much on a tangent, but just so you really understand the context of what we're dealing with, if you're not familiar with working within government.

But in my time in state government, as I've traveled out of state to other states, it's not unusual to be in a forum where, within a state, another state agency's Department of Health and Social Services, if they have an umbrella agency like that -- or not. Even if they have separate agencies -- it's not unusual for the state Medicaid director and the state public health director to not know each other and to not have even met before, and to see each -- meet each other for the first time at some national event.

So that is not something -- Commissioner Streur has been working hard on --

that's never been true. This state's too small. That's not -- never been true of Alaska just because of our size and the nature of the state, but Commissioner Streur has been working hard to break down silos between the divisions within this department. And there's certainly a long ways to go, but there has been more of that than I've ever seen before. But something that I've never seen before are opportunities for convening and working together over time around a future vision across departments that have roles related to health and health insurance.

And so Commissioner Streur and former Commissioner Hultberg started meeting together and having conversations together about the linkages between these programs and also opportunities and ideas for strategies and innovations for going forward.

So that's just all for kind of context around this plan. But for now, just starting with this framework and these conversations that we need to have separately -- because we can't do them all together here, but then we'll get the feel for it this afternoon, how this could continue to evolve when we bring these

other division directors to share with us where they're at with some of these initiatives and how they might see this helping or hindering, "this" being a state health plan document and the commission's role in that.

MR. CAMPBELL: So it seems to me -- I haven't been through it, but I didn't see anything about liaison or trying to see where the federal dollars that are spent in health care in this state come in and might be leveraged back and forth, and I'm talking about -- looking at all of the clinics out there in the state. Are we missing something here if we're talking just about state dollars? Because there's an awful lot of other entities and dollars flowing into the system. I don't have an answer.

MS. ERICKSON: I think we should let that hang for a little bit. We did -- as part of the conversation for the rest -- I mean, don't let us forget it, because -- but I think it's going to come up a lot. I mean, one of the things we are trying to figure out how to fit into this framework -- again, we're trying to understand roles and what we really have authority to do and what we can accomplish. And in the interest of not just

turning it into a wish list -- because if we're not attentive to bringing the folks to the table who can actually make the change and implement the change, it will potentially just turn into a wish list. Does that make sense?

MR. DAVIS: It makes sense. May I?

CHAIRMAN HURLBURT: You may.

MR. DAVIS: Thank you.

What I'm hearing -- and I appreciate the enlightenment -- is that the role of fostering really is a catalyst for conversation and coordination. And if that's our role to bring people together to make sure those conversations are happening, that's something I can see as being achievable by us, but that the work -- and it does not -- what I'm hearing is, it does not fall to us to tell any department what their role in achieving an objective that we've laid out is, but it is our role to say, "This is the objective. What are you -- what have you identified to achieve that objective?" And to then facilitate conversations where there's connections across other parts of state government. Yes?

MS. ERICKSON: Yes.

CHAIRMAN HURLBURT: I think we've

avoided -- consciously avoided assigning responsibility. To be honest, I would not have come up with the recommendation that the legislative audit function did, to develop a health plan, because I share the bias with the young man at the end of the table there, who was my boss, about plans and what they do.

But we are here to serve the needs of the governor and the legislature, and I think that the legislature has accepted and embraced the recommendations, and they have recommended a health plan. And so, as the commissioner discussed, we will try to make that happen.

So one of the changes -- I think that the legislative audit folks felt that we maybe were too shy, that we hung back too much from identifying responsibilities. And we'll have to do that sensitively; but, if it's something that workers' comp and Monagle should be doing, I think we have more encouragement to be specific in our recommendations.

On the other hand, I think Deb and I have had the conversation where we still also have to be specific, that we're the group of people that meet five times a year, with our December

meeting, and folks who have other lives -- that we could very easily get down in the weeds and get bogged down and accomplish nothing. So I think we would continue to be sensitive to not do that.

Deb used the word a few minutes ago, "convenor." I think that we will see that, both based on the recommendations from the legislative audit function, but also based on the time that we've done quite a bit now with studies and recommendations.

And then moving on to the next step, that one of the changes we will see, with our evolution next year in going forward, is serving as a convenor. Now, we've done some of that with the partnering we've had with Commonwealth North, with some of the functions that we've had there. And we've brought in folks involved and related to VA and health issues for seniors and so on.

But I think that we will more proactively and with malice aforethought, really, serve as a convenor and have that be a part of a function as a change. But being sensitive, we do not have the expertise nor the time nor would it be profitable to get down into operation and details.

MR. DAVIS: Well, I -- no, I agree.

I think we're saying the same thing. So we have said, "This is an objective that, after study, is worthy of pursuit."

CHAIRMAN HURLBURT: Yes.

MR. DAVIS: "And we believe you, department, have a role -- or division -- have a role in that. Let's talk about your plans to achieve that thing."

It's not our plans; it's their plans. But by being the catalyst, making sure or trying to make sure that those are the north stars, if you will, for the agencies and divisions that have to do the work to make this a reality and not a plan on Commissioner Streur's shelf. Yes?

CHAIRMAN HURLBURT: Yes.

MR. DAVIS: Okay. That's helpful.

CHAIRMAN HURLBURT: And I think, to get to Keith's question on the feds, that because of the federal preemption and their laws, the state cannot mandate certain things for the feds. And Medicare is a federal program and Medicaid, as we all know.

On the other hand, we have had Tom Harold here with us and his predecessor before that, and there will be a replacement from the

federal sector on this body -- that we have -- that the tribal health programs are kind of really, in lieu of feds, they are operated by the tribal groups but carry that federal authority and ability to reject or accept things that the state wants to do. And Val has been here with us. And in terms of the discussions, they have very much involved them.

As you well know, because your company has been so helpful in the whole process, we've got Senator Giessel's Senate Bill 169 on the vaccine bill now. And while the law cannot mandate that either the tribal programs or the other federal programs participate, clearly it's to the benefit of all Alaskans and what they want to do to get them engaged.

And so we've had conversations with the tribal health folks individually. We had one with Val when she was wearing her lawyer's hat the other day. I've talked with Stephanie Yaeger, from VA, talked with the TRICARE folks.

So I think that, Keith, I would say that our approach is to recognize that the feds play a huge part in the health care sector here and elsewhere and that certainly the folks that

represent the health care sector in Alaska on the federal side, because of our small population, tend to be more collaborative than anywhere I've worked elsewhere and were sensitive to that. But it is different, because they're not subject to the laws that our legislature passes as others are. But we can't ignore them, and they're huge. As we've said before, what government spends, with the feds being a big part of it, is absolutely every bit as much as all of the more socialist countries spend on health care. We just pile all the rest on top. So we can't ignore that big chunk.

Commissioner?

COMMISSIONER STREUR: We can't do it without everybody at the table, and I just need to reemphasize that. I was sitting here and, you know, as we're talking, started to write down some of these -- what I consider low-hanging fruit that everybody has to be at the table about -- a patient-centered medical home. I hesitate to even use that phrase, because it's not about a patient-centered medical home, it's about primary-care-driven health care.

And I don't think there is a person in this room that doesn't want everybody in

the state to have a health care provider for them, to take care of, steer, and orient their care.

Behavioral health primary care integration. When I look at a substantial portion of my budget that goes toward behavioral health and the fact that it's not integrated -- I remember, many years ago in the private sector, where I ran the behavioral health division of Sisters of Saint Joseph. And our medical director said, you know, "Streur's got behavioral health, and that's just -- that's just over there. It's not really health care. It's just over there," and he kept waving his hand like that (indicating). I think we still do that way too much. And so if they aren't integrated, we've got a problem.

Complex behavioral collaborative. We have people that have complex behavioral conditions that can't be handled in a traditional manner. What do we do with them? We ship them out of state. We have this gracious facility in Idaho that takes a substantial portion of them, and we just send them off and they take care of them.

The ones that we have taken back as a part of this program, we have had almost immediate success with great financial savings.

Our tribal partners -- I can't say that enough. The state of Alaska is unique like no other state. 60 percent of the state is off the road system. It's not that much of the population, but so much is off the road system, and the health care delivery system, the health care access that has been developed out there needs to be continued to be developed.

And we kind of, you know, nod our heads at that; but we have to sit down and -- you know, as part of your convening role, I ask, I beg, I implore that be one of the issues that you look at, because so much of our most needy population is served by that system and needs to be served by that system. However, there is lots of room, lots of opportunity to begin to expand that even further, to treat more of the folks within the facility.

Super-utilizers -- Jeff, you can't tell me you don't have those too.

MR. DAVIS: We've got a few new ones.

COMMISSIONER STREUR: That's part of the low-hanging fruit and, you know, finding out what to do with them.

And the other one is prevention, having providers and payers sitting down and talking about what a prevention system ought to look like. You know, how do we maximize vaccination rates in this state. Ward and I had regular discussions about that, and an example is that the tribal system seems to have mastered that pretty well. However, outside the tribal system, we're pretty abysmal. And so even with the tribal system support, we're, what, 37th in the nation in terms of our vaccination rate. So we're in the bottom half.

Fluoride. We're seeing more and more communities that are abandoning fluoride. It works. It's a good program, and what do we do? How can we collaborate on that?

Smoking is still a problem. We spend millions of dollars a year on smoking prevention, and, you know, how do we integrate that into the health care that we deliver?

And finally, the scourge of it all, alcohol and, you know, what do we do about it? How do we help? How do we make that -- all within the prevention component. And I don't know how we would do it, in the department or in the state,

departments together, without enlisting where most of health care is delivered and paid for, which is outside of state government, and having every single provider group and every single payor at the table, talking about how do we address this. Because it's -- until we reach across the table with everybody, we're not going to get to a solution on it.

And my challenge to you all is that convenor role, the bridge-builder to help us move this forward. I can't do it. Jeff can't do it. David can't. And I look out -- Becky can't. It's got to be all of us.

And earlier I said, "Be bold." That's what we have to do, is we need to be bold because just fixing the rates is not lowering the rates. Controlling the rates is not going to fix it. It may fix it in 48 states. It's not going to fix it in Alaska. And we all need to be together on this thing. I've spoken with several of the groups, several of the provider groups, and they're willing; but somebody has got to get everybody at the table to talk about it.

So, thank you.

CHAIRMAN HURLBURT: Just a time

check. We've got just a little under half an hour left in this session, and we wanted to have some update on the Affordable Care Act and, related to that, on the Medicaid Reform Advisory Committee, and then talk a little bit about the engagement with the private-sector employers and the group of the HR directors for a number of -- both the Alaska Native for-profit corporations and some of the other larger corporations where they have come together, stimulated by the challenge that they are all facing -- most are self-insured, but with the intimidating increase in health care costs that they're seeing.

So I wonder if we could maybe deal with those things. I'll start out maybe with the Medicaid Reform Advisory Committee. I think most folks have seen a list of the names. The governor -- go ahead, Deb.

MS. ERICKSON: I included the governor's press release in your packets, in case you hadn't seen it. And it is -- where did I put it? It is behind Tab 2, the second document behind Tab 2.

And one of the questions for the commissioner -- or he might have a question for

us -- is: What could and should the Health Care Commission's role be in supporting, collaborating, coordinating, staying out of the way of the governor's new Medicaid Advisory Group.

CHAIRMAN HURLBURT: So this group will have their final report in November, so it's a fairly limited amount of time for delving into that. It's done in the context of Governor Parnell wanting to do what's right by Alaskans in terms of health care, what's right by Alaskans in terms of what can the state afford, and I think -- I'm showing my own bias -- maybe doing what's right by the country, where we don't seem to be concerned about the printing-press money that we're living on. And clearly, the health care costs that the feds pay are being paid largely by printing-press money now.

So the intent is to do the right thing there in terms of all of those parameters. Clearly, by those who have been appointed, there will be some vigorous discussions, because some different viewpoints are very sincerely held by the folks on that. But they are all Alaskans, and I think, just as we started out with Jim and Jeff and others saying what they're representing on the commission, the folks on that group will also be

representing all Alaskans.

So are there maybe any questions? Or, Commissioner, I don't want to put you on the spot, but if you have something to share on your vision on this --

COMMISSIONER STREUR: Sure you do.

I don't know what's going to happen out of this. I honestly don't. It's a very unique group of individuals. In the press release, I found out that I'm going to be the chair of the committee, but several people are going to be called into play on this thing in terms of helping staff.

This is not going to be an easy group to manage, but neither is the task going to be an easy task to accomplish. We have so many sacred cows in Medicaid that, it seems no matter what we do, it seems we're going to be stabbing one of them in coming up with a process and a way to more wisely provide Medicaid services to the state of Alaska. It's $1.6 billion right now. We have about 140,000 people. Do the math yourself. It's over $10,000 per person, and it's a substantial expense. It goes up every year $18- to $20 million. $38 million a few years ago. And

while we have put some controls on, Medicaid continues to grow.

And so this group -- when I say a disparate group, most of them don't have Medicaid experience. Most of them are not Medicaid consumers. None of them are -- most of them are not Medicaid providers. And so it's people that really don't have direct skin in the game, other than they know that we have, as Representative Keller put out, declining revenue and that we can't sustain -- the $2 billion-a-year loss in the budget, if we continue at the current rate, is real.

It's been beat into me, or I beat it into me -- I'm not sure which -- and I check oil provides every single day. I check output every day, because we are 90 percent dependent on those two things.

So the committee, and your role in the committee -- I ask that, as you have opportunity, you participate. As you are willing to be bold, be bold and make a suggestion. It's not about do we expand Medicaid or do we not expand Medicaid -- I hope it's not going to be about that -- but it's about how do we create a better

Medicaid system that's sustainable. And a better Medicaid system is not necessarily a cheaper Medicaid system alone. It's about access. It's about higher quality. It's about the right care at the right time with the right person. And it's about well-coordinated care.

And then, finally, yes, it is about cost. Cost has to bear into that or be considered into that, because our population continues to grow, and the complexity of our health care continues to exacerbate. PCA waivers is a good example. Those of us that are 60 and older, we get to go to the doctor more often than those of you that aren't there. And the aches and pains come. But it's how do we compensate for that, how do we deliver a better system. And it's an opportunity with a huge, huge challenge. So I ask you to be a part of it. I ask you to help us with it.

CHAIRMAN HURLBURT: Any comments or questions related to that?

Yes, Dave?

MR. MORGAN: I guess I sound like a broken record, because I say it a lot. I've given a lot of presentations on it. But as someone that's

worked and ran small clinics and medium-size clinics in rural parts of the state that were both community health centers, tribal, and a group that was actually under contract with a rural health department -- except for animal control. You don't like seeing nurse practitioners taking out pet stuff.

What strikes me is, looking at this stuff from a system standpoint as an economist, you know, we have these four or five gigantic planets of VA, tribes, state, Medicaid, and all the other stuff is kind of smaller moons that are being directed by the gravitons.

But what happens with Medicaid -- and that shows you how dull my life is when I think about it -- what we are really talking about is actually a great opportunity in a way, because we're really talking about that 15 or 20 percent that's using 80 percent of those Medicaid resources. We're really talking about 27,000 -- depending on births and deaths -- to 28,000 people primarily in 10 or 11 zip codes. Medicaids do tend to congregate around where they can get services. In some ways that's bad, because then they can really utilize them; but in another way, it gives

many opportunities of ways of working on their access, how we process that, and how we purchase and deliver the services that are going into that mix.

28,000, 29,000 people in community health is not that huge of a number. It's not 150,000 in Medicaid that's using $1.6 billion; it's basically roughly 25,000 to 30,000 using 80 percent. And I've actually seen charts provided by Deb in a program that our former commissioner of administration gave, and it is true that between 10 and 18 percent of any group is consuming 80 percent of the resources that are being spent.

Now, the end-of-life equation does enter into and changes some of those paradigms, those metrics. In my mind, the real problem with Medicaid is not the fellow or the family that is between jobs, and a kid breaks their arm, and so you have Denali KidCare or whatever; it's individuals that are in it for many, many years and are consuming these resources.

So, in my mind, you're right. You've got a lot of -- as has been said, we have a lot of countervailing forces, and everybody is fixed in place by our orbits. But if you scrape

all that away, what we're really talking about, if you want to do effective change in quality, access, and cost, we're actually talking about 15 to 20 percent of the population to work with.

So in my mind, if you approach it that way, although there are a lot of issues, there's a lot of countervailing forces from providers to insurers, taxpayers, several people out here, several people in the legislature.

Actually, I think it is a doable task to come up with some good stuff here if we all throw in our shoulder. I know I sent several e-mails and made several phone calls to tell them I'll help in any way, even if it is to stay away, if they want me to stay away. And one or two of them went, "Well, you know, now that you mention that" --

(Laughter.)

MR. MORGAN: But I think, as a commission, we should do everything we can to help them. We have -- I've kept everything that Deb, staff -- and some of us have even given out some stuff. It fills a whole bookcase. And it's not plans; it's basically data information, how do things work, how do all of these moving parts -- as

we push people into it and as they come out on the other side.

So I would think that we would be a resource to this group to move this along, because, man, in actuality -- maybe you guys who have been in government for 30 years -- you're really talking about finishing this thing up in August or September in order to have it go through the -- you know, a couple of public -- I'm going -- I'm making my own, you know -- like I said, I have a dull life.

But when you look at how -- just our process of coming up with our yearly plan -- and many of us have been working at this table for three, four, five years -- you're talking about really finishing this stuff in August, September-ish, having some hearings, preparing a document, proofing it. It's not they have to start writing the document in November. If you put a timeline up here, it's actually August in my mind. I mean, unless it's going to be -- and I don't think it's going to be a two-pager here. This is going to look like our yearly report in some ways, I think. Maybe.

So for whatever it's worth, that's

what's bouncing around in my mind. As my father, who I saw last week, told me, I do have one of the finest minds of the 16th century.

(Laughter.)

MR. MORGAN: By the way, he's 86 and still has a full practice at this time.

So that's where I'm going. It may be where no one else is going, but that's never stopped me before; right?

COMMISSIONER STREUR: It has not.

MR. MORGAN: I'd like to hear what the other commissioners think, in my mind. Where do they see this other advisory group -- if they could write them a letter, like what I've done -- which I plan to do -- what do you think? Where do you think it could go, and what do you think -- how this is going to roll out? No comment?

MS. ENNIS: Well, in respect to the advisory group, certainly if you're looking at that kind of timeline, it does seem like an impossibility. For individuals who are coming from the, you know, somewhat unfamiliar perspectives of the depth and breadth of Medicaid services, the first action will be simply to have some understanding.

And I think that's where it will be very important to have the contacts and other folks either from their side of the table -- but some way to be able to get up to speed in terms of both the breadth and depth of the services. And then as you begin to look at whether it's the 21 percent users or just how this group decides to approach analyzing, you know, kind of the priorities of reform need.

There is just a huge job here; and I think, you know, in Alaska, to be able to understand the impact of change immediately is important too. You know, who are the users and what is the -- you know, what are their needs? And then sometimes even a little bit of change can make a very significant negative impact.

So, again, the awareness of that, grasping that fairly quickly is going to be important. So it's a huge job. A huge job. So I would begin to -- I think if I were part of the group, you know, what are those priorities? What are those areas of -- you know, that we can make change in a positive way quickly? What are the priorities? And then going from that.

But it is a very, very big task.

Being a Medicaid provider, I can only imagine, you know, how I would want to see it begun.

CHAIRMAN HURLBURT: Allen?

MR. HIPPLER: Thank you.

I have to say that I'm encouraged by a lot of what I'm hearing. And I know how difficult this is going to be, because we're facing a situation -- kind of like the commission. When I joined the commission, basically what I heard is, "We want to increase the quality of health care and access for people and decrease costs," which is very difficult to do, of course.

And today, a little bit of what we're hearing is, let's have -- let's be fiscally conservative but have access to health care regulated by need.

In a usual market, demand for goods and services is characterized by price and the intersection of cost of delivering the service and demand for the service at a certain price. And when you take away demand regulated by price and replace it with demand regulated by need, it really changed the demand curve and increases the overall cost.

What I'm hearing is that I think

you're aware of that, and you're really pursuing cost-effective measures. And I'm just -- I would just encourage you that the fiscally conservative part of that is extremely important. Thank you.

CHAIRMAN HURLBURT: Keith?

MR. CAMPBELL: I'd like to ask the commissioner a question.

We heard David's numbers of 15 to 18, 20 percent using 80 percent of the resources. I think you've documented that. But in your own mind, as you look at the situation as a problem, is that 15 percent, 18 percent, a lot of it malingering, just people who've got nothing else to do but go to the provider and because it's free? Is that an incentive? Is there any way you could build a disincentive into the system? I know you're hamstrung by federal regs and all that sort of thing, but I'm sure you've thought about that problem a lot. Do you have an answer?

COMMISSIONER STREUR: I have. And do I have an answer? No. I do not believe it's malingerers.

MR. CAMPBELL: Okay.

COMMISSIONER STREUR: I believe it's people with complex medical and behavioral

conditions -- and/or behavioral conditions. I believe that it's people who do not have regular access to health care. I believe it's people that like emergency rooms, and that's where they get their primary care through. And I think it's people who abuse their bodies, whether with alcohol, other drugs, tobacco, obesity. Help me, Ward.

(Laughter.)

COMMISSIONER STREUR: It's those folks. It's also, you know, folks who have lifelong, complex developmental disability conditions that put them into it. We have a young man that moved up here last year from Rhode Island, two years ago from Rhode Island. He has an immune deficiency, and his medications run, I want to say, $20,000 a month to keep him alive.

You know, it's those. Some of those we can address, but I can go back to partnerships. A lot of the -- and we used to call them high-flyers. That's not demeaning. It's folks that use the system an awful lot. And out of that 15 percent, there's a subset of those that we can definitely have an effect with. But that's going to take, once again, everybody at the table. It's going to take ASHNHA sitting at the table and

saying, "We got Joe down here showing up at the emergency room three nights a week." In my personal health plan, we had a guy that spent over 300 nights in the hospital a year by figuring out conditions to get him into the hospital so that he could get three squares a day. And he was disabled. He was challenged in many respects, and he was also very good at crafting conditions to get him into the hospital overnight. And it took us about three years to get him into an effective system that could take care of him, but it saved us over $500,000 a year.

And it's those I think David is talking about, and we have to begin to identify those. But the hospitals have to be working with us. They have to say, "This guy is showing up. Here's what we're doing." It's physicians in the emergency rooms working with us. It's law enforcement working with us because, so often, law enforcement, you know, are the taxi that delivers them to the jail -- or to the hospital.

That probably didn't answer your question, but --

MR. CAMPBELL: Yeah, you did, because I've been on that side of it a lot.

COMMISSIONER STREUR: Okay.
MR. CAMPBELL: The fact is -- and we've been grumbling about it before. And every community knows who they are. So with that said, if there was an effective system for referral and the service was there -- but in lots of places, there aren't. The ER is it, and that's the problem. We no longer give them a pink ticket to Seattle.
CHAIRMAN HURLBURT: I'd like to share my observations on this. Because I think David's take on the time frame is right. It not only mentions November, it mentions getting it into the governor's budget; so that's not very long from now. And the commissioner's comment that he hopes that it won't devolve into just a discussion of do we expand Medicaid or not and the Affordable Care Act -- because, clearly, looking at the representation there, that will be an issue that will be there and will be a challenge to the chair of the group to manage.
So if the vision for the advisory group is to look at Alaska's Medicaid program, which has continued to grow in cost -- and then you've mentioned a couple of examples of very costly enrollees that come in, the Medicaid

enrollees that -- the national projections are that the risk of this hepatitis C, for which these new, very costly drugs and others are coming down the pike, is probably at least twice that of the average for the population, which means if you take the recent projection that the one-year, first-year cost for California, for all Californians, could be between $18 and $29 billion to treat the hepatitis C-positive individuals.

And if you kind of extrapolate that to our population, and then to the Medicaid population with the increased risk, that's $100 million or $200 million more there. And the projection is that the highest-cost years will probably be about 2019, 2020, not even the first year. So there are some big shadows there.

So what I don't see in any of the members of the group is expertise on what's happening elsewhere in the country in Medicaid. And we have been pretty reactionary.

In Alaska, I think, we're not in the forefront of some of the newer things for a lot of reasons. And you know what's happening elsewhere, and Margaret does and Alex does and many others. You have those contacts, but not many

people in Alaska do. And I don't see that here, and you're not going to have the time for the seminars to educate them.

So how can we hope that that group will come up with recommendations to you and to the governor of what maybe some others like New York state or Washington state or other states have done, some things that have increased the quality of care, improved the outcomes in terms of survivals, and controlled the costs that may be applicable and that we ought to try in Alaska? How can you get a disparate group that doesn't have that knowledge base already to wrestle with those kinds of issues?

And your answer might just be, "I'll get down on my knees every night and pray to God."

(Laughter.)

COMMISSIONER STREUR: I first want to respond to the selection of the committee. You know, it's sort of like you don't get to select your family. When it's the governor's task force, you don't get to select the members. And it's -- we're going to have to figure out a way to put pinpointed information in front of them to consider.

And it's going to have to include recommendations to legislators. They have staff, and we're hoping they'll be part of it. I already mentioned Emily. She keeps cowering every time I mention it, but she's going to have to be involved in the thing. Josh and I will be front and center on it. We're going to have to put these recommendations in front of them and explain to them the good, the bad, and the ugly of what it is we're facing.

One of the things that I'm going to push very strongly is helping our consumers understand that it is a three-legged stool: It's the provider, it's us as a payer, and it's the recipient of services -- the patient, if you will. And they have to be involved in this. They have to be engaged in this. And, I mean, it's going to be a big part of what I'm pushing, is how we put that in place and where have other states done it.

It could be something as simple as a co-pay in some situations. It can be -- some states are looking at not rewarding, like we have, behaviors that contribute to health care issues -- smoking, obesity, and tobacco.

And, you know, it's going to be

tough, Ward. It's really going to be tough. It's a very compressed time frame. I wish David hadn't brought that up. I already don't sleep at night thinking about it this, but he's not far off. I'm thinking I have until mid to late September, and then October is going to be just a huge month.

MR. MORGAN: If it's okay --

CHAIRMAN HURLBURT: Yes.

MR. MORGAN: I wasn't necessarily restricting it to --

COMMISSIONER STREUR: Sure you were.

MR. MORGAN: -- what I call -- my comments on the 15 to 18 percent were not necessarily the guy that's in the bed 300 nights a year.

I've experienced -- and I think a lot of people around the table have -- are especially the big three that I've run across in rural and urban community health centers, hospitals, and tribal, is basically diabetes, asthma, and obesity. And I honestly -- I have been at the admitting area, and that patient that comes in a lot, a diabetic, who is -- this is the third trip this month into the ER room, and they are

truly sick. And I've heard the admitting provider say, "Well, what happened?"

And "I ate a gallon of ice cream yesterday," and they are a diabetic.

And so, I mean, I think it's a little larger than the 300-night guy. I do think it's -- and you're going --

COMMISSIONER STREUR: I just gave you my bizarre example.

MR. MORGAN: Well, we can -- you know, we can go out to here; but, really, the big bucks of changing it is how we buy, what we buy, and how we deliver it. And all of those can be better.

But if you're really -- as we would say in the NC FAST system, or the case management system in North Carolina, that we're working to do the things that you've been talking about for several years -- is where the real cost savings is. And only if -- you can't cure it, this primary disease, but just by making the 20 percent -- the 10 or 20 percent healthier, and the way you buy it. And not for all 150,000 across the whole state, but that 25,000, 30,000 that's concentrated in those eight to ten zip codes, you could have a significant impact on the resources

and dollars spent, and they are actually healthier.

I mean, you know, this is not changing eligibility or even the real dollars that you're paying out, but by simply shifting that paradigm by 10 or 15 or 20 percent, have drastic -- because they're using the highest-cost entities -- the ER room, the hospital bed, and script.

And like I said, I'm going to blab to the advisory group, if I can, if I'm allowed, and I'm going to -- I want to talk about that, that you don't necessarily have to treat the whole forest to treat the blight. You may only have to really -- to make effective change for the better, for cost stability and for access, to deal with those 25,000 or 30,000 individuals that we're really talking about, in my mind.

And I think we've all talked about it in different ways, but I think we pretty much all agree -- or sort of. At least as much as you can in a room on a Friday at 10:00. Maybe if we'd all got stuck in Sitka, like I did the day before yesterday, we could have had an all-day meeting on this, sitting at the airport, I guess, in Sitka.

And like I said, I think we are going to have to help, guys. And we need to be an

asset. We need to support them. I know your staff, I think -- Deb, who has done a great job. I mean, Herb and Deb herding this group over the last few years is a pretty good testament to that management skill of persuasion and jawboning.

But it's going to -- for them to meet that, I think we're all going to have to help them in this. And however it turns out, I think we should throw in as much as we can. I know we're all volunteers, but we're going to have to help them if they're going to meet that goal with something that we all want to see that's to the good, you know, or at least does no harm or has negative impacts.

CHAIRMAN HURLBURT: We're a little beyond our break time now, and we probably want to keep to the schedule for the day. We will have a chance to come back. We didn't get into the discussion of the private sector and employers, so we'll come back to that this afternoon. If there are some other things -- I know, Keith, you had another comment, and --

MS. ERICKSON: Emily did too.

CHAIRMAN HURLBURT: What's that?

MS. ERICKSON: Emily did too.

MS. ENNIS: I can wait. We can talk about it later. Thank you.

CHAIRMAN HURLBURT: Do you want to -- is it a quick comment or --

MS. ENNIS: Well, just a quick one. I would say you mentioned, Commissioner, the individual that used 350 days a year in the hospital. Well, I'm concerned about those individuals that use every day in long-term care, and I think that's going to be another very tough subject to look at. Because we have quite a few people in long-term care right now -- children with critical medical conditions that have been taken out of hospitals and allowed to live in their family homes and individuals with developmental disabilities. And then there is our senior care that's growing.

And those are big numbers, and they are -- it's every single day of the year that they're going to be receiving Medicaid support, whether it's in the smaller assisted-living homes or Pioneer Homes. So that's a daily price tag that I know we need to look at closely.

COMMISSIONER STREUR: Thank you.

CHAIRMAN HURLBURT: Keith, do

you --

MR. CAMPBELL: No. Thank you.

CHAIRMAN HURLBURT: Why don't we come back at five after 10:00, then, and reassemble.

9:52 AM

(Off record.)

10:09 AM

CHAIRMAN HURLBURT: Let's go ahead and get started. The next session -- it's a couple hours till noon time, and we're going to be talking about health plan development, as we started out this morning. But this will be in four specific areas, four specific segments of our state government.

And so we have four folks here with us. They'll be here with at least three of the four to talk about the programs within their division, within their areas of responsibility and some of the things they're doing now.

So it's not a panel of the four, but it's more for them to have something to say and then open it up and have a discussion with all of us.

We have Lori Wing-Heier. This is her first chance to be here with us, our first

chance to see her. She's new in the job as the director of the Division of Insurance, and we really welcome, Lori, you coming here today to meet with us.

In fact, because you weren't here this morning, I think maybe, as you four move up to these four chairs here, we'll just go around and have all of us on the commission introduce ourselves to you.

But we welcome you to your new job. Obviously, it relates very much to what we talk about on the commission here, and we look forward to working with you.

So I'm Ward Hurlburt. I'm the chief medical officer for the Department of Health and Social Services and chair of the commission.

Jim?

MR. PUCKETT: Jim Puckett from the Department of Administration, representing the Office of the Governor. Welcome.

MS. WING-HEIER: Thank you.

MR. DAVIS: And Jeff Davis, President of Premera Blue Cross Blue Shield of Alaska, representing insurers and Alaskans.

MS. WING-HEIER: Nice to meet you.

MS. ENNIS: Emily Ennis, provider in Fairbanks, Alaska, representing the Alaska Mental Health Trust Authority.

MS. WING-HEIER: Nice to meet you.

MR. CAMPBELL: I'm Keith Campbell. I'm the consumer rep on the commission.

MR. HIPPLER: Allen Hippler, Chamber of Commerce.

MR. KELLER: I'm Wes Keller. I know we met yesterday, albeit briefly.

MR. MORGAN: Dave Morgan, representing the community health centers, all 23 programs and 142 clinics.

CHAIRMAN HURLBURT: So if we could have -- Margaret, if you and Mike Monagle and Mike Barnhill and Lori, if you could just come up and take these chairs here. Margaret, we'll start with you.

They do not have a formal presentations for us, but they may have some notes, and we'll give you a chance to start to talk.

Margaret Brodie is director of the Division of Health Care Services where the Medicaid program rests. And of the $2.5-billion-dollars-plus that the state spends for health care, the

biggest chunk is in Medicaid, as you heard the commissioner say, the $1.36 billion. So it's almost getting to be real money there.

And it's a time that's getting tighter. One of the stories I tell is, I remember about three years ago, when the commissioner was testifying in the legislature. And it was when we had had the ARRA money, during the economic recession. And the feds had been giving us a larger federal match, and that went back down from what it had been.

So it was something in the neighborhood of a $130 million increase. And at that time, my interpretation of the response was, "Oh, that's terrible. Okay. What's the next item of business?" But that is not the response that the commissioner would get today, and that's why we're all concerned. And that's more healthy. That's better now.

So, Margaret has a huge challenge there and the biggest chunk of the state money.

But, Deb, you had something.

MS. ERICKSON: Yeah. I just wanted to provide a little context for this conversation for the commission members and then for our

distinguished guests who are joining us, so they understand kind of where we're at, where, you know, we've been working on what the commission's role is.

We started off, in the first three years, being very much kind of a study and advisory group, advisory on state policy to legislators and to the governor, specifically with the legislative auditor's review, that we could help, working with the Department of Health and Social Services, facilitate the development and implementation of a plan.

And so we shared with the commission members this morning that we've put this framework together and have started developing it. It might look very, very different by the time we're done, but part of this meeting is having a conversation about what our role as a commission should and could evolve to over the next three years, if we're continued.

And so if any of you at the end of table have any thoughts about what the commission can do to help and support you in your efforts, if there's anything beyond just being the convenor and coordinator and pulling some information together and documenting it for the public and for policy

leaders.

And for commission members, I've pointed you to this statewide health plan template earlier. In front of that document are some one-pagers where I pulled out just in a simple bulleted list around our eight core strategies for each of these areas -- at least for Medicaid workers' comp, and for the Department of Administration, the initiatives that are currently listed in the longer documents, so you have kind of a simple cheat sheet to look at as we go through these.

And I think the first one is actually legislation. It's behind the governor's press release on the Medicaid Advisory Group. And so if you pass the one on legislation, the next one is Medicaid. So if you find that, it's just a one-pager. And behind that I included just one handout on the initial health screening tool for the Medicaid coordinated care initiative, just so you'd have something a little more tangible to put your hands on. I thought you might be interested to see it. Margaret had shared it. It's just one of the initiatives she's going to talk about.

This is an opportunity for the

directors and the deputy commissioner to kind of update us on the status and implementation of some of the main initiatives they're working on now and just have a conversation with you all as we work on kind of figuring out and getting our heading for the future.

Except for Lori. I promised her -- since she's like all of what, two weeks into this job or so?

MS. WING-HEIER: Four weeks now.

MS. ERICKSON: We're not going to ask her any policy questions today. It's just an opportunity for her to introduce herself to us and for us to get to know her little bit.

CHAIRMAN HURLBURT: And there are comparable one-pagers for DOA and workers' comp, and that was part of what I very specifically had in mind when I was complimenting Deb on the book she put together for us there. If you haven't had a chance to look at them, they'll be helpful. But you don't have to look at all of them when Margaret is talking.

Margaret, let's start with you.

ALASKA STATEWIDE HEALTH PLAN DEVELOPMENT
CONVERSATION AND GROUP DISCUSSION

MS. BRODIE: For the record, I'm Margaret Brodie, the Director of Health Care Services.

MS. ERICKSON: Can I -- especially for commission members, we usually have a sound system, and the folks that used to provide it in Juneau don't do it anymore. So everybody around the table is going to really need to speak up. I'm hopeful that folks on the phone at least can hear us; but I'm most concerned about the folks in the back of the room, and especially now that you all are at the end of the table with your backs to them.

I think some of our commission members who are very soft-spoken need to really speak up for the folks in the back of the room too. So, thank you.

MR. DAVIS: Thank you, David.

MR. MORGAN: I'll try to speak up for you, Jeff. Okay?

(Laughter.)

MS. BRODIE: So you have heard the commissioner talking about results-based

accountability and results-based budgeting, and we've really been working on that throughout the whole department. A lot of people don't understand that Medicaid is not just health care services; it's senior disability services, it's behavioral health services, it's health care services, it's public assistance, and it's also the Office of Children's Services.

And for a long time, we were all working in these silos, knowing what our specific programs needed and trying to get there, and we weren't working in a coordinated effort. We were all just going off and doing our thing and not even thinking how it would affect other divisions, not only within our department but within the state.

So we've changed a lot of that. We have a Medicaid director's meeting now where we invite everybody in. We give them all the latest literature that has come out. If somebody is changing something in their division that has to do with Medicaid, they need to bring it up to this entire group for them to ask questions. They need to state, if there's going to be regulation changes, how that is going to affect recipients, how that is going to affect the department, how it

will affect other divisions.

So it's really a new way of thinking, and it's a lot more collaborative and it's actually been really, really good, because we were able to catch a few things that one division wanted to change that would have pretty much thrown another division under the bus, the workload that would have been entailed from the change -- which was minor to them, and they needed that, but they didn't realize that, if you change that, every single person has the right to a fair hearing, and we only have two hearing reps.

And so it's worked out really well. We've been able to postpone some things so that we can plan and put the resources in place for when there is a backlash on something or if we need to change relations down the road.

So we have all been working closely, and we've also been working closely with public health, with Ward, with Deb. One example is on our super-utilizer project that we're working on right now. We found out that, through what's called hot-spotting -- so we took a look at where everybody actually is located that's a super-utilizer, and we found out that 25 percent of

them are in one part of Anchorage, in one zip code. And so we found out that they didn't --

MS. ERICKSON: Could you define "super-utilizer" for the group here?

MS. BRODIE: The super-utilizer is somebody who uses the emergency room more than four times a year, is how we defined it.

And so we found out there is this one neighborhood, and it turns out they don't have any health care in their neighborhood. The closest healthcare is a hospital, and it happens to be on the bus route. And they can even walk there from this neighborhood.

So we got together with public health, who got together with the proper people with the municipality; and so it's a whole network, getting the word out that we have an issue here. It's not really a Medicaid issue, because, although it's 25 percent of mine, but not everybody in this neighborhood is on Medicaid; so this is more of a population health issue that we need to look at.

So we do go to public health. We talk to them. We've engaged the land trust in the neighborhood there, trying to see, you know, what is it that we can do. We've engaged the primary

care association. What can you do? Can you negotiate somebody going in there and opening a shop there to provide the services?

So that's the way thinking has changed. You know, three years ago, we would have gone, "Huh. That's interesting," and done nothing about it. And now we are making sure that the proper agencies and the proper people are notified.

So let me just continue on with the super-utilizer, since I brought it up already. So we got kind of like a nongrant from the National Governor's Association. They're paying for us to travel to academies and for them to come up, and we're reporting to them on a weekly basis, on a monthly basis, and on a quarterly basis.

And so what we're supposed to do is identify the people who over-utilize our services. So we went out and we looked at all the people who use the emergency room more than four times a year. But that's not good enough, because: Why did somebody use the emergency room four times a year? Do they have cancer? Do they have diabetes? Do they have behavioral health issues? Do they have substance abuse? Are they drug-seeking? Why are they using the emergency

room more than four times a year?

So we went ahead and we looked at the diagnoses of all these people and what they were being treated for, and 50 percent of them have behavioral health issues. 50 percent of them. And the majority of the rest have chronic conditions.

So we're looking at, if we need to decrease the amount of emergency room use, we need to ensure that they're getting the proper treatment for those chronic conditions so that they stay out of the emergency room. If they have behavioral health issues, we need to look at: Do they have a primary caretaker? Do they have a behavioral health provider?

And so we've put together a matrix of all this information, and we put out an RFP, asking providers to case-manage these people. We're expecting them to case-manage approximately 200 people. There are well over 8,000 super-utilizers. We are going to pull 1,600 in right off the bat into this program. We are hoping to provide eight contracts servicing at least 200 people.

So now it gets even trickier, because people can see whatever providers they want

to see. So how can I bring people into managed care when they have choices?

And so all of these people technically qualify for our lock-in program, also called care management, because they're over-utilizing service; so they're an outlier. But our care management program could not handle this many people at all. And every single one of these people can request a fair hearing if we put them into the lock-in program.

So what we're going to do is, we're sending them all a letter saying, you know, "We see that you've been using the emergency room a lot. We have this really great program that you can voluntarily join, and we'll make sure that you have a primary care provider, if you need behavioral health, dental, I mean, any type of provider that you need, we'll be sure that you have it." So we're going to try the nice way first, and hopefully we'll get 800 people.

But I'm not that optimistic, because this is all new. People don't like to be managed. Some people will jump on it. The elderly will jump on this, because they need that type of care coordination; and they're not getting it from

somewhere else. But there's a lot of people that won't, and they're going to resist.

So the next letter is going to be, "Again, we've got this wonderful program. You qualify for it. By the way, you also qualify for the lock-in program, so we highly suggest you volunteer before your number comes up in the lock-in program."

And so we have a series of three letters that progressively push them into it until we get over 800 people that volunteer. And we need over 800, because we're pretty sure that the minute we start managing some of these people, they're going to close their eligibility for Medicaid for one month, because this is what has happened in the past. They close their eligibility so they get dropped from the program, and then they come back in the next month, because they can go retro three months back. But that break in service will take them out of the program. But they never lose benefits, because they can get retroactive for three months.

So we're prepared for that. If they drop their Medicaid, they are to remain in the care management for three months after, so that

when they come back on, there's continuity. They're picked up by the same provider, and it just keeps going.

The RFP was on the street back in December. It scared our providers, because we asked for metrics. We asked for quality. We were very, very detailed in the reporting and what had to be done. And they got scared and let us know they were scared, that they didn't believe that they could meet what we were asking for. We apparently went too far.

So we took another look at the RFP. We put in -- we took a look at the reporting requirements. We scaled them back, because I don't want people reporting just so I have a bunch of statistics. It has to be meaningful. It has to have some use going forward.

So we scaled back what the reporting requirements were. We gave them tools to use. And it's really cool, our health screening tool. It looks at housing. It looks at transportation. It looks at, you know, if they have food. It looks at the whole person and gives them an acuity rating, because we also don't want the providers cherry-picking who they are going to

case-manage. Because if you case-manage all the easy people, that's not fair to somebody else who is taking on people with higher acuities. So we are trying to ensure that everybody gets sort of like the same population to manage.

And so that tool is really, really neat. We developed that in conjunction with the National Governor's Association and the National Association of Medicaid Directors in a couple other states. So it's really user friendly, easy to use. The reporting requirements coming back, we haven't put out there yet. I haven't finished reviewing them, but they are scaled back. And it's literally a form that they fill out, so they're not going to have to do all this extra data analytics to report back to us.

So we changed the RFP. It's supposed to -- it was supposed to close next week, at the end of next week, but we got word that at least one if not more hospitals want to apply for it, but they don't have enough time if it closes next week. So yesterday I extended it until the end of April. And the rush to begin with, why we went out in December and everything else, is, I thought for this grant I had to have results by

June 30th, but the National Governor's Association told me that just what we've done is results; so we're okay. We need to take our time and do it right.

So we're really excited about that. We have quite a few people working on it. That's really going to be the first step to see: Will our recipients be managed? Are we going to be able to manage them? Will they volunteer for it?

I also increased the capacity of our lock-in program, where they have typically only managed 200. I brought them up to 300 this year. But now their contract reads that they have to manage between 300 and 1,000 individuals, so that when push comes to shove, when we get the fourth letter out saying, "You qualify for the lock-in program," I actually have someplace to put them.

We're not going to be able to take everybody in at first, but this is just the first step. And I see this program growing over time, where we're going to be able to take a look at the outliers. We're going to be able to identify them very quickly and get them in the program.

I've been working with the emergency room doctors, and they're telling me all

the reasons why people are over-utilizing the emergency room, you know, from drug-seekers to people with chronic conditions. There's also a population of people out there that enjoy being sick. That's the only time that they get attention. And they go in, and they're with their significant other, their spouse, their somebody. That's the only way this person is getting attention.

So that goes to the behavioral health issues that we're going to have to address, and we're going to have to try to change that behavior. And every emergency room doctor knows every one of these people intimately. And so, in working with them and through this project, we're really hoping to make a difference and decrease the cost.

The goal in the first year from the RFP is, we want them to reduce the emergency room use by at least 50 percent overall, over the whole population, not -- it doesn't have to be just one person. Because the person that uses the emergency room maybe four times a year, you're not going to get them halfway. You might get them 10 percent. You might get them 20 percent. And so

it's a learned behavior. So that's the overall goal.

And so of the 1,600 people we're going to take into this project, if we avoid just one emergency room visit per person, we save $2.1 million. And think -- we want to at least avoid two for the four and over. So we're thinking that this is going to be really cost-effective and save a lot of money for the state.

Another thing, Ward mentioned about the new Hep-C drug. That is really, really scary to me for a lot of reasons. It's extremely expensive. It's like $1,000 a pill. But I see this as the first of many. So the next miracle cure, how much is that going to cost us?

Right now, we have just over -- well, 1,247 Medicaid recipients that have hepatitis C. So if they all were to receive this drug, it would cost millions, and the state really can't afford it. But I'm looking at, you know, this is going to cost Medicaid millions. What is this going to cost Corrections, where their population has Hep-C?

So we've been working with the MED Project, which works with evidence-based medicine;

and we're trying to find out: What is the criteria for someone to be approved for this drug? Because literally, how can you deny somebody a cure? You can't. You can't. But there are other therapies that have a 50 percent success rate. So can we put in place, "Well, you have to have tried this first before we go for the Cadillac version"?

So we're working with the National Association of Medicaid Directors, with the MED Project, with public health, with the administration, and we are trying to get criteria in place before this really devastates our budget.

I think it's the first step. Like I said, what happens with the next miracle cure? How much is that going to cost us? And we don't have choices. You can't not cure somebody of something that will otherwise kill them.

So that's really scary for me. We've put in place prior authorizations for a lot of these types of things. We also -- we put in place prior authorizations for anything that is really high-cost, like MRIs, CAT scans, prescription drugs. And with the new MMIS, that went a little rocky for a couple months; but we are now back to where we need to be where the prior

authorizations are going through either same day or next day. We did get a little bit behind just because of system defects. We weren't able to move the prior authorizations to an approved status. So there was a lot of telephone calls and, "Yes, it's approved. Go ahead."

So we've had a lot of success. We've saved millions of dollars with our imaging prior authorization this last year. And what we saw with that mainly was a sentinel effect. So, all of a sudden, they're not prescribing MRIs as much. They're not doing the CAT scans as much. And that's what we expected, and that's fine.

We just put on the street a contract for psychotropic medication review. I'm sure you've heard many times that people are stating that, for the kids in foster care and in the juvenile system, that they're overmedicated. So we have an independent third-party contract that is going to review the medications, psychotropic medications on all kids in OCS custody, DJJ custody. And we will be adding the kids on Medicaid to that. It's already in the contract, but we're jumping up to it. So we want to be sure that the kids are receiving the appropriate therapy

for their condition, and so we're really excited about that. That's just -- we just signed the contract this last month.

The MMIS system -- we implemented the new system on October 1st. We started up the system knowing that we had 40 defects. That was an acceptable risk. Well, it turns out that there were really thousands that had not been identified; so it's been a rocky start.

We've been working with our providers. We've been doing advance payments, paying them outside of the system. And we have literally fixed hundreds of defects already. Every Wednesday night and every Saturday night we deploy fixes to the system. As of today, there's 548 more that still need to be fixed, but we're prioritizing them.

Every week that goes by, we're paying more and more providers. We still have issues with school-based services, with labs, with durable medical equipment suppliers, and a few other little, tiny things; but, for the most part, we have the majority of the fixes in.

The major frustration for our providers are the remittance advices that they get.

Somebody got one that was 10,000 pages last week, and so they asked us to pay for their paper, which we can't do. So one of the number-one things is -- and it's because it prints everything four times, every line four times; so you can imagine what these hospitals are getting.

MR. MORGAN: Well, it comes electronic.

MS. BRODIE: Yes.

MR. MORGAN: That's the way mine do.

MS. BRODIE: It was an electronic one that printed out to 10,000 pages. Yeah.

So we're working on a fix for that. The problem is that they built it to be a letter rather than a report. So for audit purposes, it's not reproducible. Well, when it comes to money, it has to be reproducible. You have to be able to have that audit trail.

So we are putting a fix in in two steps, and the first step is to eliminate the three extra lines for every transaction. So it will at least bring it down to 25 percent of what it is now. So it will be 2,500 pages instead of 10,000.

And then the next step is to find

another venue where it's a report that can be reproducible. And we really need that because, for example, this last week, all the remittance advices disappeared off the system. So if a provider didn't get in there really fast and print their stuff out, it's not there.

And so we really need this to be able to be reproducible in the future. We have that fixed. We were able to find a backup of them and put it out there, but these are the kind of issues. And it's a web-based system, and to get the environment stable, there's -- I can't even tell you how many billions of lines of code there are in the system. And so they have got to go through all this, find what it is that's causing something, and put a fix to it.

So it's going a lot better. We're paying just about every type of provider now. We're paying them correctly, too, because we weren't paying anybody correctly for the longest time, because they built the system with two decimal places instead of four. And that fix went in three weeks ago now, so now we have to reprocess all those claims. But I don't want to reprocess all those claims until I fix the RA, because

everybody's staff will quit.

So those are the kinds of things we have to think about and keep going. We are working really closely with Xerox. We're working one-on-one with providers. If providers are having problems now, we're asking them to contact us. We actually spent a whole day and a half with a hospital last week going one by one through their claims. And it turns out 50 percent of the problems were in the system, and we were able to go out there and correct them just this week so that their claims can process; but half of them were also they were billing incorrectly. And so this one-on-one is the route that we have gone now with people that are still having problems, and it seems to be working out well.

Frontier extended-stay clinics. This was a project that Medicare put out there. We're actually not sure how we got permission to join a Medicare project, but this is where people in the rural areas are actually kept in the clinics because they haven't reached an emergent condition, but they're really not well enough to send back home. So they're monitored in these clinics to determine, you know: Do they need to be medevacked

somewhere, or can they be sent home? Will the condition pass so that they can be sent home?

And so this was a project for like a year that Medicare did, and we thought it worked really, really well. We saved a lot of money not having to medevac these people.

But Medicare ended the demonstration project on March 31st of last year, and so we went ahead and we put in a state plan amendment saying, "Hey, this really works for us. We want to continue it."

And they came back and said, "How were you in it to begin with?"

So we're like, "We don't know, but we were; and you paid us."

And so now we really want this to continue, because it does -- it provides a real added benefit here in Alaska. So we took back our state plan amendment, and we're working with the different entities that provide this service and saying, you know, "We're still working on this. We are trying to get it through."

The initial Medicare report comes out next month. They have promised us a copy of it so that we can go back in with the state plan

amendment hopefully by June 30th and put it the way it needs to be so that we can get this service.

The problem is that they made a special code for this service. And if Medicare is not going to use it, they might turn it off on us. So we have all these kinds of things going on. So we may have to put it out there in a different format than what has traditionally been out there. So we're looking forward to doing that.

We're working on a juvenile justice Medicaid program. And what this is, is juvenile justice has to pay for the medical care for all the kids in their facilities. And they get a special general fund allotment to do so, but they pay the prevailing prices for everything. They don't get a discount. They're paying full market value.

So we're creating a state-only Medicaid, so moving those funds over to Medicaid for state-only. So these kids are going to be enrolled in Medicaid and be able to get Medicaid rates for the services that they receive. So we're expecting that that's going to save a lot of money.

The other thing that it does is that, when these kids leave custody, we're going to

be able to determine if they're eligible for Medicaid or not at that time. So they'll have a safety net. They'll have a continuation of services. So it will go from a state-only to one that we can get federal financial participation for when they leave. And also if they're hospitalized overnight while they are incarcerated, we can also get a federal match for that also.

So we thought we were going to implement that April 1st. We've done all the work. We've done all the research, all the background stuff. But, to be honest, I didn't want to break MMIS, so I have put it out till July 1st. I don't want to take a chance on hurting any of the progress that we've made going forward. So right now, I'm looking at July 1st. If we don't have a lot more things fixed by then, it may go out another quarter; but it's definitely happening in this calendar year.

Okay. Preferred drug list. We update that on a regular basis. We did some work this last year, though, that's pretty cool. Because the preferred drug list -- have you ever seen it? It goes on for like page after page after page. And so we were looking at that, and it's

like, you know, the pharmacists and the doctors might be able to glean out, "Hey, what's changed?" But why don't we just tell them what's changed? So we also -- so we put out the preferred drug list, but now we put out a separate document that says, "Here's what's changed since last time" so that people don't have to go through page after page after page and try to figure out what changed this time. So I think that that has helped people a great deal, too, this year.

So we're trying to be really responsive. We're trying to look beyond. You know, we're working with other divisions, other departments; and we're really trying to look out for our recipients and our providers.

And to that end, we do have a Medical Care Advisory Committee in Medicaid, and this is a group made up of recipients and providers. They represent different groups. And so we went ahead, this last year, and we created a work plan. We brought in results-based accountability into this committee. And so we went ahead and we worked, I think, like for four days overall putting in a new work plan. What is our goal? What are we really here for? Are we just

like meeting once a quarter and complaining about everything and bringing up issues? What is it that we're doing?

And so with this work plan, they came up with some really good things. And every meeting now, they're going through this work plan and ensuring that they're staying to it and that they're following their charter, their purpose, and what it is that they do.

And at the last meeting that we had -- I can't remember if it was January or February -- we went ahead and went through the work plan, and we aligned it with the work plan of this commission, because all these different entities can go off on tangents, but we all need to be moving in the same direction.

So we went through and we made sure that all our priorities are in alignment with this commission's, so that was a really, really good exercise. And we were actually really surprised how aligned we really were.

So, that's it.

CHAIRMAN HURLBURT: Thank you, Margaret.

I think maybe what we'll do is

wait until the end. And Lori, we'll go next with you, because I understand you have an airplane that you need to get to.

MS. ERICKSON: Margaret is on that same plane.

CHAIRMAN HURLBURT: Okay. So I have to say about Margaret that the new Pope is a man of the people, from all we hear; and I have it on good authority that if Margaret gets through the MMIS with her equanimity that she always has, she's on the fast-track for canonization.

(Laughter.)

CHAIRMAN HURLBURT: You are really doing well, Margaret. Thank you for coming and sharing with us.

Lori, if you could maybe introduce yourself to us and tell us a little bit about your background and what you bring and a little about bit about your vision. And then, if there are any specifics that have come up with Margaret's conversation there, we'd appreciate that.

MS. WING-HEIER: Well, I think Margaret and I have a lot of specifics that we've been working on in the four weeks.

As you know, I'm Lori Wing-Heier,

and I'm now four weeks -- almost four completed weeks on the job. So I come from a background of insurance. I was what was Brady and Company and has been Marsh now for a number of years, for a little over 16 years. I've been in Alaska for about 30, but I was with Brady and Company for about 16 of those.

Then I went -- one of my clients decided I'd be great to be the director of risk management, so I went to Arctic Slope Regional Corporation, and I was their director of risk management and actually sat on their benefit committee as a part of that position until I accepted the position as the Director of the Division of Insurance. I took some time off, and this position opened about the time I was thinking it's time to go back to work. And so I guess all the stars aligned, and here I am.

It has been somewhat like drinking from a firehose. I'd been sitting in the chair for maybe four days when we got the notice of the extended transition plan under the Affordable Care Act, and so we've certainly been doing a lot of research on that, on the pros and cons and stuff just so that the governor has all the information

we can provide him on that. We have been certainly monitoring the legislation as it's been provided on the various bills that are impacting insurance -- both property and casualty, workers' compensation, and health care.

There is a ton to learn in this position, and I truly feel like I'm drinking from a firehose, but I've had -- Marty has been incredible in trying to direct me or show me or teach me or whatever as we've been working together the past four weeks, and I've had a tremendous amount of support from others.

So I think that with a little bit more time -- and I promised Deb I will have my schedule set so at these next meetings I will be more prepared and be able to tell you something good or bad or what we're seeing. Certainly trends -- we're watching trends for costs as respects health care and what we can do. We realize -- I've worked with Mike a little bit on some of the trends -- prescriptions being one, hospital ERs.

I would tell you that some of your comments I found very fascinating, because when I was in the insurance book of business, part of what

I did was, I was the broker for years and years and years of a health corporation -- Nanielik, Norton Sound, ASHNHA, Kodiak Area Native Association. And so I spent a lot of time in the rural hospitals and clinics. And when you were talking about -- I knew exactly what you were talking about, why those things happen, and the cost to get people out of the villages or out of the larger cities, Kotzebue and stuff, and in to Anchorage for treatment, or Fairbanks.

So I do bring a little bit of knowledge of having health care experience and what you struggle with in rural communities as far as healthcare-providing.

So that's kind of my background and where I'm at. And I'm excited to be here as the Director of Insurance and to participate in this commission.

CHAIRMAN HURLBURT: Thank you. Welcome. We appreciate you being here, and I look forward to talking with you more.

I'm wondering -- Mike Barnhill -- Deb had said earlier possibly you had some other commitment. And you're the next biggest chunk of the state's budget, with $700 million plus for

state employees, retirees and dependents. So I wonder if we could turn to you next.

MR. BARNHILL: Sure. I'd be happy to.

My name is Mike Barnhill, Deputy Commissioner for Department of Administration. I've been in this position for just over three years. Prior to that, I was an assistant attorney general at the Department of Law since 1998. And prior to that, I was in private practice as an attorney here in Juneau and also in Anchorage.

I've had the privilege to work with Commissioner Hultberg and Emily Ricci, who are in the audience, on health care issues, and Jim Puckett for the past three years. It's just been an absolutely fascinating experience.

A bit about Alaska Care. That's the plan that we administer. We have just over 84,000 covered lives which are split between two plans: our active employee plan, which has just over 17,000 covered lives; and then our retiree plan, which has just over 64,000 covered lives.

That doesn't include all of State of Alaska employees. Actually, most State of Alaska employees are covered by a union health

trust, the ASEA health trust; and that population is a couple thousand employees larger than our employee population.

All told last year, we spent over $600 million in health care claims and then an additional $100 million that the State of Alaska contributed to our union health trusts in the form of a benefit credit. So, as Dr. Hurlburt just said, you know, our spend is $700 million a year on health care for the State of Alaska employees and retirees, and it's increasing.

When Commissioner Hultberg and I started about three years ago, we had almost immediate concerns. You know, our health costs had more than doubled in the space of ten years. And at the same time, the oil production curve that pays for these costs had substantially declined. And if you line up these two graphs of healthcare costs going steadily up at a rate of 7 to 9 percent a year, with oil production going down steadily at 5 percent a year, you can see there is going to be some substantial disruption at some point in the future if one of those lines didn't change. And I think that's one of the theories behind the governor's oil tax plan, is we need to change that

oil production line. So that's been put in place, and we hope that that will have beneficial effects in the short term.

With respect to health care, we had a number of concerns, one of which was, unlike Medicaid -- I mean, I hear what Margaret was saying, and I'm just sort of salivating with jealousy over what she's able to do in terms of "We know who our super-utilizers are, and we know we have 1,247 individuals with hepatitis C." That kind of glimpse into data has not been something we have been able to do. We literally have just a handful of staff, and we're continuing to work on that to manage the care that's delivered to 84,000 covered lives.

The primary way that we've engaged in addressing our health care trend, which we do not believe is sustainable, was to look to our vendor partners. And so we've spent the better part of the last few years working on our requests for proposals to retain a new third-party administrator.

With our plan, the third-party administrator not only processes the claims that come in, about 30,000 claims a week, which we

simply can't do internally, but it also brings to the table a discount provider network. With our prior third-party administrator, they had what amounted to a rental network through the Beach Street Multiplan program; and the discounts that that provided the plan were relatively small. And we knew that. We could see that change in trends. When we went from Premera to HealthSmart, our claims costs went up a fairly marked amount.

When we did the request for proposals and the bids came in, one thing that we did differently -- it was hugely important -- was, we asked each of the proposers to reprice 12 months of actual claims in their networks. And what came back was truly astonishing, because the spread between what we had paid and what we could have paid, were we in a different network, was in excess of $50 million in one year. And so we knew we had done the right thing to go out and get those proposals to see what additional savings we could have by having a more aggressive network.

The theme of networks and network utilization and steerage has really been prominent in our transition. We retained Aetna. And I'm glad to have the MMIS issues sort of providing

cover for us, because we've definitely had some bumps along the way. And folks have said, "Well, you really don't want to trade jobs with Bill Streur." And I say, "You're right." Or Margaret.

(Laughter.)

MR. BARNHILL: But there have been some bumps, because I think, you know -- particularly in our retiree population, there is decided resistance to being steered into a network. Our network utilization -- I haven't seen the numbers recently; but the last time I did see numbers, it was running around 50 percent, which is woefully inadequate. We really need to work on that some more.

But we are making some progress. I think Aetna, particularly in the Lower 48 -- and half of our retirees live in the Lower 48 -- has a much more robust network there. And we should see some substantial savings in the Lower 48 spend. And there's more opportunities for network utilization, so we're expecting to see higher utilization numbers in the Lower 48.

In Alaska, it's a different story; and that's primarily because our specialist provider community has historically resisted coming

into a network, whether it's Premera, Beach Street, or Aetna.

But we are starting to see some progress. I mean, I think the providers -- and they're all very, very smart individuals -- are looking at the same graphs that we're looking at with respect to the fiscal future of the State of Alaska. The reason why we had to do oil tax reform to boost production is, the revenues are going to come in leaner over the next ten years. In fact, the Office of Management and Budget, a few weeks ago, presented a ten-year projection scenario that was essentially flat. What message does that send to us? Well, we need to figure out how we can bring in our health costs as close to flat as possible.

That is going to be an extraordinary feat for us, and how in the world do we do that? Well, the most promising way to do that is to try and increase network utilization, enhance the networks that we have, encourage providers to get into network, try to search for the win-wins for providers to get into the Aetna network and the national -- Aetna has two networks, their own proprietary network, and then they have a

rental network, the National Advantage Program.

And so since Aetna has come on board, we now have Bartlett Hospital in network for the first time, which is a huge boost for our plan. And we now have Juneau Bone & Joint in Aetna's National Advantage Program network. And so now we are starting to see specialists, orthopedists come into network. There's discussions happening across the state in terms of doing that. And so that's where our focus is. We really want to continue focusing on network utilization and building our networks in Alaska.

Another step that we took -- probably a smaller step in terms of overall numbers, but nevertheless I think important to our overall goal of boosting networks -- is, we put in place a dental network. Our actuary, Buck Consultants, had recommended consideration of putting in place a dental network. We have never had a dental network before; but apparently, over the past few years, the Delta Dental network has come into the state. And we retained Moda -- which used to be known as Oregon Dental Services -- as our third-party administrator for dental claims, and then they brought with them the Delta Dental

network in Alaska.

And what they have done, at least in comparison to, you know, how successful we have been in the past with respect to building a medical network, is I think really nothing short of amazing. In the space of a year, they've built up a dental network in the state of Alaska that now has 311 dentists, which is well over 60 percent of dentists in Alaska.

And they did this in a pretty interesting way. Our recognized charge methodology, prior to retaining Moda, was at the 90th percentile, which pretty much meant that most of your dental bill was going to be paid for.

Delta came in and said to the dentists, "We will reimburse at the 80th percentile if you're in network, and we'll reimburse you at 75 percent of the 80th percentile if you're out of network." And that's a pretty extraordinary thing to do. I hear the chuckling. But I have to say that, pretty much overnight, in the space of a year, we created a dental network in the state of Alaska with fairly robust network options for our members.

And as a result of that, for the

first time, we are reducing the benefit credit that the State of Alaska pays on behalf of every state employee -- well, at least the state employees that are in the Alaska Care plan. And we are using that number to negotiate with our unions, and so we've recently concluded a negotiation where we used the same reduced benefit credit in that negotiation.

And so when we talk about, you know, the goal of bending the trend, we have actually now done that. And it was modest. I don't want to tout this too heavily, but we reduced our dental costs, our premiums for our economy and our standard dental plans, by $18 a month. And there is no impact to our members, because we reduced the premiums for both options. And so there is no out-of-pocket difference for them, at least through the end of the calendar year.

And I really appreciate what Moda has done. Now, it hasn't come without some noise, particularly in our retiree community. Some of our retirees are used to seeing fairly expensive dentists, and there are some dentists in some areas of the state that charge maybe twice what other dentists -- most dentists are charging for a cavity. We've heard various anecdotal things about

these dentists. And so there is some disruption there.

But the interesting thing with our retiree dental plan is, they pay 100 percent of the cost of that. The state doesn't contribute anything to that. And so through the introduction of this dental network, we're going to be able to reduce the rate of premium growth for our retirees, which has gone up at a fairly steep rate since 2010, about 7 percent a year, which, you know, quite frankly, is a pretty steep increase in a dental plan.

And so a husband and wife, if they're paying for, you know, a couple premium, the premiums have gone up over $300 since 2010. And we think, with the introduction of the network, we're going to be able to substantially slow that premium growth and potentially reduce the premiums that the retirees pay. We'll have to wait and see. I look at the cash flow every week coming in from our providers, and the dental claims are coming in at substantially less than they were last year. At this point, it looks like in excess of 15 percent less. It's still early, and so we don't want to bank on that 15 percent number.

But that really -- I hate to say this to the providers around the table, but that's what we are looking for from the medical community, because I honestly don't know how, as a state, we can sustain these medical costs over the next ten years without some reductions in the cost's growth curve. It's got to happen.

What we're looking for is a win-win-win -- a win for the providers, so that you can be sustainable over the long term; a win for the state and our plans, our retiree plan and our employee plans, so that we can be sustainable and bring our budgets in, as the legislature and Office of Management and Budget want to come in; and then a win for our members because one of the biggest issues that our members have to deal with are some of these balance bills that come in at extraordinarily levels, particularly from some of the specialists in the state.

We get those calls. We've been getting those calls for years. And the balance bills are incredibly disruptive to our members' lives. And that's one of the primary reasons we want to bolster network utilization and network participation by providers, is to get over those

balance bills.

In terms of other steerage mechanisms that we've introduced, similar to what Medicaid has done, we've increased the number of procedures for which precertification is required, substantially increased those. And that also is coming with a fair amount of noise from our population. But we think increasing the number of precertification requirements is actually a benefit to our members, although I'm sure very, very few would agree with me on that. Particularly when you don't have robust network options, it's very possible that a member may seek care for something that could be extraordinarily expensive and they don't know it. They won't know it until after the care has been received, and it's expensive, and there's a balance bill associated with it.

There are also quality issues with some of the care that our particular precertification list is targeted at, and we want our members to be educated on what are some other alternatives in terms of procedures that are maybe as or more efficacious than what the doctor may be recommending.

So we added -- I don't know. Jim,

I can't remember -- 17 to 20 procedures to our precert list. We had a fairly robust precert list up until 2009, and then I think the perception within the Department of Administration was that precertifications were largely a hassle and didn't really add much value; and so we pared that down to one or two, MRI spine and MRI knee.

Aetna came in, and it had a fairly robust and lengthy precertification list that it uses with its contract providers within its network, and we decided to simply adopt that almost in whole.

And our hope is that this will not only help educate our members, help our members avoid balance bills, but will also help our members think twice about network utilization. So in a way, our expanded precertification list is a form of steerage to consider network opportunities. And the reason why that is, is because when you go in network with Aetna, there is no precertification requirement for the member. Aetna imposes that precertification entirely on its contract providers.

So we will continue to monitor. Aetna started on January 1st, and we are looking

forward to getting over the bumps like Medicaid is. We hope that will happen soon, but we're really looking forward to seeing: How are the costs coming in? Are we reducing our trend? Can we deliver a flatter trend for the legislature and the Office of Management and Budget? Can we deliver high-quality health care to our members within that lower trend? And so that's something we're very anxious to see what happens.

Deb has given me a number of topics to discuss from your work plan, and so I'll jump into those, unless there's any questions on that introduction.

So the first one is "Ensure the Best Available Evidence is Used for Making Decisions." This is a really good point. When we started three years ago, one of the things we were hearing, particularly in our appeals, was the lack of access to medical expertise. So in our retiree plan, for instance, we had four levels of administrative appeal: We had third-party, level one; third party administrator, level two; division, level three; and then, finally, the Office of Administrative Hearings, level four.

And I was visiting the Office of

Administrative Hearings, which also, even though it's independent and we have absolutely no role in how they adjudicate appeals, they do report through me to the commissioner. And I was visiting with one of the administrative law judges, and he had a neurology textbook open on his desk. And I don't know if he was working on a DRB appeal, but he's an attorney like I am. And he said, "Mike, I'm not a doctor. And I've got this neurology textbook open on my desk, and I have no access to medical expertise." This is a problem.

The same was true at the division level. And when we came in, there was a substantial backlog in appeals, which may have had something to do with the lack of access to medical expertise. And so we dealt with this in a number of ways. First, with respect to claims adjudication, by bringing on Aetna, as opposed to HealthSmart, one of the benefits that Aetna brings to the table -- and Premera may have this as well. And, Jeff, you're welcome to chime in and get your equal time -- but one of the things we definitely appreciate about Aetna is that they have documented their view of what care is medically necessary in a set of what they call clinical policy bulletins.

And they're posted online. And so members can identify, and providers can identify, whether Aetna believes something is medically necessary and will be covered or not before the care is provided.

And to the extent the care is provided and the care is denied, coverage for the care is denied, then a doctor or provider can look at Aetna's clinical policy bulletin and say, "I disagree with Aetna's view on medical necessity, and here's a study that I rely on to show that this care is medically necessary." That dynamic, that discussion, that ability to have that debate based on evidence did not exist in our plans until January 1st.

And that's a huge benefit and a huge step towards evidence-based medicine in our plan, is the documentation of what is evidence-based, or at least Aetna's view of what is evidence-based, so we can have these discussions and debates.

Now, our members have complained about Aetna having a more conservative view of what is evidence-based. And my understanding, from folks that have done this longer than me, is all third-party administrators have different views on

what is medically necessary. I suspect that it's similar to lawyers. If we put three lawyers in a room and ask them for an opinion on a particular issue, you'll get three different opinions. That may be similar for doctors. If you put three doctors in a room and ask them for their opinion on medically necessary, you may get three different opinions; but at least we have the ability to look at the peer-reviewed studies and have that discussion.

We did more than that, though, a couple more things. We inserted at Level 2 -- prior to Aetna, we had the third-party administrator take care of all of Level 2 administrative appeals. We interserted, for medical issues, an external review organization. They could look at the medical issues at stake and come up with a decision. That didn't exist before. This is an Affordable Care Act-compliant level of review, which we think delivers substantial benefits to our members because it's independent.

Now, interestingly, we've touted this -- I've met with literally hundreds of retirees and different stakeholder groups over the past few weeks, and there is a fair amount of

skepticism amongst our membership about the extent to which these external review organizations -- which are required now by the Affordable Care Act for plans that are subject to the Affordable Care Act. There is skepticism as to whether they really are independent. And so the refrain I hear repeatedly is, "If Aetna is paying for them, they're not independent. The fix is in, and that level of review is not meaningful."

And our response is, "Well, somebody has got to pay for them."

And we have had a few members say, "Well, the membership should pay for them," but I'm pretty sure that that is a very, very tiny minority of folks that are willing to actually front the cost of that.

We're continuing to look at that. We learned recently that, under the Affordable Care Act, the federal government has hired an external review organization. They've retained Maximus, and apparently Alaska is participating. I don't know if this is through HSS or through some other organization, but we're one of just a handful of states that are participating with the federal government in the Maximus external review process.

And so we're exploring now whether we can use Maximus in our plans; and that would completely, I think, alleviate the concern that Aetna is paying for the external review and that, therefore, the fix is in. I don't know what's going to happen as a result of that inquiry, but it's something we are definitely interested in.

I don't believe that the fix is in. I'll be quite candid about that. Aetna has four external review organizations. They rotate cases through them. We believe that they are honoring their obligations under the Affordable Care Act and that the intention of the Affordable Care Act was to truly have an independent external review of medical-necessity issues.

An additional thing -- oh, on Level 2, I should also say -- and this is required under the Affordable Care Act -- is if the member prevails on the medical issues at Level 2, we've provided that the plan will pay immediately, which, again, I think is a fairly extraordinary procedural mechanism to put in place. There was never, prior to this, any provision for the plans to pay immediately.

But when you consider the cost of

protracted appeals, not only to the plan but to the member, and the delay, it made sense to put that in. And we are going to reserve our rights to pursue an appeal following the payment in case there is some profound issue that just needs a higher level of appellate review and decision and guidance, but the member won't be prejudiced as a result.

And we did that even though -- and we did that in the retiree plan, even though the retiree plan is not subject to the Affordable Care Act. Our employee plan is subject to the Affordable Care Act, but we are grandfathered; and so that provision hasn't kicked in for us yet. We do anticipate surrendering our grandfather status at some point in the future. But we did it both because we thought it made sense for the plan and for the members to give them an early exit if they prevail on medical evidence.

The final thing that we did is, we brought in medical expertise through contracting with the Department of Health and Social Services; so we've got Dr. Hurlburt on an RSA, Dr. Malter on an RSA, and they meet with us weekly. And I have to say, having their expertise and involvement with

us on a regular basis has been just wonderful. And I thank the department for being willing to loan this medical expertise to us. And they have gotten involved in a wide variety of things. They've gotten involved in helping us make policy decisions, helping us evaluate our RFPs -- Dr. Hurlburt served on the Proposal Evaluation Committee -- and helping us on some just really tough cases, whether something is medically necessary or not.

And so getting that medical expertise involved in our day-to-day administration of the plans has been a very large step towards accomplishing this goal of using evidence to make decisions.

The next bullet point is "Increased Price and Quality Transparency." Now, this is a hard one in the state of Alaska. I think, for many providers, they are reluctant to say in advance what something is going to cost, and quality transparency is something that I think is also very difficult to get.

There are some tools that are available. So FAIR Health, which is the successor to Engenics in terms of a database that's used to

compute what is usual, customary, and reasonable of a recognized charge -- FAIR Health has a database that's on line, fairhealthconsumer.org, and our members can go to that and get some sense of what care may cost if they go out of network. If they go in network, of course, there is no risk of balance bills; so it would just be the 20 percent coinsurance amount.

We have -- Aetna has brought to the table some price transparency tools that can be put on a mobile phone. And it's really too early to tell the extent to which those are being utilized and the extent to which our members find those to be helpful.

There are third parties. Castlight is one of the primary ones that will work with a third-party administrator, an insurance carrier, to provide price transparency and quality transparency to members. We've had multiple discussions with Castlight. I think -- I don't know if they have presented to your meeting now, but they're very -- that's a very interesting product, and I believe you'll probably see more and more of those products in the marketplace. But right now it does appear that Castlight is a leader

in this industry.

The State of Indiana has been a pioneer in consumer-driven health plans in the public employee space, and they have retained Castlight. And they were here earlier in the legislative session to present their experience with consumer-driven health plans. And I believe they also gave a metric on their utilization of Castlight. They just turned on Castlight a year ago, and I think their utilization was around 20 percent. It's fairly low, but it's still early to tell.

But we certainly want our membership to begin working on educating themselves as to the care that they're receiving, the cost of the care, the quality of the care, the alternatives that are available, because it's important to them; right? And it's important to the plan in terms of managing the trend.

The next one is "Pay for Value," and, of course, that's absolutely what we want to be doing, is pay for value, not overpaying for value. I think, if I could restate that, that really is the theme here. We want our members to get high-value, high-quality care. We don't want

to overpay for it.

A sub-bullet here is "Explore Patient-Centered Medical Homes," and that is something that we have done intermittently over the last three years under Commissioner Hultberg, is explore those concepts. Right now, we're focusing on transition with Aetna, getting some basic plan administration issues straightened out. But once we get those done, I think we can move back to a more strategic focus on accountable care organizations, the basis of medical homes. And I know Medicaid has explored a pilot program for a PCMH that we're interested to learn more about.

"Evaluate Use of Centers of Excellence." This is another form of network and steerage that Aetna has brought to the table. It's relatively modest, but it, nevertheless, is a form of steerage. They did bring with their proposal a Centers of Excellence network of transplant hospitals. There are 140 hospitals on the list. It has all the major hospitals that you can think of that provide transplant care in the United States. Dr. Hurlburt looked at that list. I think Dr. Malter did as well. And their conclusion was you really don't want to get a transplant at a

hospital that's not on this list.

But what we did in addition, for the first time in the retiree plan, is we did put a network differential in there at Aetna's recommendation. So it's a 20 percent network differential. If a retiree goes out of network for a transplant, the coinsurance rate is 60 percent, as opposed to 80 percent. And while I completely agree with Dr. Hurlburt that you really don't want to go to a hospital -- you know, Omaha Community General Hospital in Kansas to get a kidney transplant, nevertheless we did put a network differential in there for the first time; and that is steerage. Interestingly -- well, I'll back up.

So to get into that network, there are a variety of metrics that you have to satisfy, including quantity. So if you do -- if a hospital does less than 40 kidney transplants a year, you can't get in the network. And there are other quality metrics that are required as well.

But it does seem to me that that benefits our members because I know, for myself, if I have to get a kidney transplant, I do want to go to a provider that does at least 40 kidney transplants a year, that they know what this is.

We met with retiree groups. We did hear from one person that said, "Well, quantity is not everything." So there is even pushback within our retiree community on that, and we may continue to have disagreement and discussion and pushback from our retiree plan; but we do believe, in this particular context, that having that network differential and that steerage absolutely protects our retirees and protects the plan from a kidney transplant that might go wrong that's performed in a hospital that really doesn't have the experience. We don't want providers practicing on our members; we want to go to the hospital that has the expertise. So that's, I guess, our first foray into Centers of Excellence.

"Engage Employers." Well, we're the employer. I'd say we're pretty engaged.

And "Improve Care on the Front End." Primary care clinics -- that's definitely something that we've had multiple discussions on. We've had health care costs -- Management Corporation of Alaska -- I don't know if they have come before you, but they are essentially a purchasing cooperative of primarily union health trust plans. They have opened an on-site clinic at

Alaska Regional in Anchorage, and they have invited us to consider participating with them; and that's under consideration. I know that they are considering additional on-site clinics that would help benefit their membership. So that is certainly something we are looking at.

"Explore PCMH Complex Case Management." Well, Aetna does provide complex case management.

"Improve Care for Seriously and Terminally Ill." There's no question that end-of-life care is a huge cost-driver in any plan. In our employee plan, we had a claim spike of a 20 percent increase in claim costs last year because of a dozen -- less than a dozen end-stage renal disease cases. And so getting the ability to manage those folks and move them into appropriate care, but high-quality care, absolutely is a goal.

"Focus on Prevention." In 2012, we did a number of things. We turned on First-Dollar Preventive Care in our employee plan. Initially we had it anywhere, in network or out of network. We quickly decided we better bring it into in-network only. We created a position called the Strategic Initiatives Health Care Coordinator

position to help with strategic initiatives, including a wellness program. And so Emily Ricci was our first employee in that position. We created a wellness committee for our state employee plan. We created a Weight Watchers at Work program for our state employees, a very popular initiative.

It's still too early, really, to measure the efficacy of these efforts. As I testified yesterday at Representative Keller's committee, there is definitely a segment of our population that wants these initiatives. They want the Weight Watchers at Work. They benefit from the Weight Watchers at Work. They want access to First-Dollar Preventive Care.

Our first year of preventive care wars fairly noteworthy in that utilization didn't change one bit. And I don't have insight as to whether it's the same exact people, but the same number of procedures essentially were performed. Our cost went up $1 million and provider costs went up 17 percent, which made me sort of instantly jaded about the benefits of first-dollar care.

Now, I know this is kind of a national initiative under the Affordable Care Act, and nongrandfathered plans have to adopt many of

the procedures on the U.S. Preventive Services Task Force list. And I guess time will tell who is the primary beneficiary of first-dollar preventive care, but the fact that the unit cost went up 17 percent in the first year I think is a concern. I think it's a concern for our plan, and I think it's a concern for the country. But all that being said, we support preventive care; and we'll continue to follow through with these initiatives.

We do not have preventive care in our retiree plan, and this has been an issue of longstanding concern for our retirees. Our actuary has calculated that it would cost about $2 million a year to add the full spectrum of preventive care for our retirees, not first-dollar but subject to the deductible.

And that's not a lot of money when you're talking about -- in our retiree plan, roughly $500 million is spent. Nevertheless, our retiree plan has a huge unfunded liability associated with it, $3.8 billion. So we don't think, from a fiduciary perspective, it's responsible to add access to care that would cost the plan more without finding some way to pay for it.

And so we've been in discussion with our retiree community, and we'll continue that discussion about, okay, from a policy perspective, we're not opposed to adding preventive care, but how are we going to pay for it that doesn't add to the unfunded liability? We've had a variety of responses and good discussion on that.

"Build the Foundation of a Sustainable Health Care System." And I think that was probably my introduction, and that's what we are all about here, is: How are we, as a state, going to sustain a healthcare plan for our state employees, for our retirees?

You know, with the defined benefit plan, we know we have to have this health plan last another 60 years, and we know we have a $12 billion unfunded liability. We know that, you know, continuing trends that we've -- our trend has flattened over the past few years, but a 7 percent trend is not going to work. It's going to be not sustainable, so that really is our motivating force, and pretty much everything we do every day is: What can we do to be sustainable?

I have talked too long. I apologize, but I hope I answered your questions.

CHAIRMAN HURLBURT: Thank you, Mike, and thank you for what you're doing.

Let me just respond, before we go on to Mike Monagle, just on, understandably, your sense of if you get three doctors in the room, you might have three opinions there.

But in terms of evidence-based medicine, it is rare to really understand the concepts of that evidence. But I think if you do, you would, more often than not, come close to a consensus on that. It really is a discipline.

The problem is, we have -- whatever it is -- 800,000 experts in the country, a couple hundred thousand who belong to the AMA and the reels don't, but we're all trained to be experts, to be individuals. And then we believe sincerely that we are, and the public often believes that we are. But with that discipline, I think you really can come to it.

For example, with Aetna, there have been a couple of situations that you've been engaged with where Alex and I came to a little different opinion. On one, Aetna very quickly changed their policy because of just going through the process. And on the most recent one, they may

or may not. It is a large national organization, and it's so easy for Alex and me to be nimble.

But just to end with a story on that, when I worked with PacifiCare, who is now part of United, my boss was the vice-president who -- and maybe a mutual friend of Lydia and me -- Linda Vorvick there. And Linda had an aunt. She had -- and Linda had worked for the Providence system as a medical director when they were having their group model clinics in Seattle and other areas that unionized and just blew up -- a really bad situation -- and got out of that.

But she'd been in that job, and then she was with the company that I was working with. And she had an aunt who lived in Vancouver, Washington, and was going to Kaiser. And Group Health in Seattle and Kaiser were kind of cousins in that system.

But her aunt had breast cancer. And so Linda was in a job where she had been a competitor of the Kaiser system, of the Group Health system in that. But her aunt had breast cancer, and her friends were telling her, "Why don't you drop out of Kaiser" and assumed that she would be able to get other insurance, but "Get

other insurance, and then you can go see any of these oncologists all around," because she was in the network model for Kaiser. And they were directing her.

So here was this woman, Linda Vorvick, who was my boss, who was a competitor of the Kaiser system in her various lives. And she said, "I said to my aunt, 'Don't you dare change. That system will not let you do the wrong thing.'"

And, you know, obviously that's not 100 percent true, because everybody can make a mistake. But, really, the imposition and the requirement for the evidence-based medicine -- the docs may hate it. The patients may hate it at times, but it's absolutely every bit as much about quality as it is about cost.

But it is about cost. In one of my lives, my title was Vice-President for Cost Containment. In this day and age, we wouldn't be so insensitive as to give me that title. But that is the reality: It is to help contain costs. And along with your contracting, that's the other arm. And you figure with the $600- to $700 million that DOA spends on health care, if 30 percent of that, roughly, either does no good or does harm, that's

$200 million, $250 million there, which is the key to a level budget with a declining throughput.

So I'd say it is about cost containment, but it's absolutely about quality also.

Yes, Jeff?

MR. DAVIS: Thank you.

Mike, so thanks for a very thorough description, as a very large employer, of how you're looking at the future. And I commend you and Commissioner Hultberg and others for the courage to take on some of the issues you have. I know it hasn't been easy, but you are; and so good for you.

And thank you for being so candid about the lack of the -- perhaps of places where the predecessor organization had some gaps and that you have filled. So, thanks. That was really good to hear, because I think you will see the difference. We will all see the difference. The people who are covered by the plan will help to avoid some of that 30 percent that's unnecessary. And the people of Alaska who are paying for the plan, along with the recipients, will avoid that unnecessary cost and harm.

I just would note one thing, in that all those capabilities you've described for Aetna are fantastic, but I would just note that there are other high-performing health plans that have at least that level of expertise or more. And there are at least four of them in this market. Aetna is a fine plan, and I hope they do a fabulous job for you. But, for the record, I just wanted to note that.

MR. BARNHILL: I was pretty sure you would want to take that opportunity, and I'm happy to have you do so.

CHAIRMAN HURLBURT: Thank you.

Yes, Allen?

MR. HIPPLER: A clarifying question, sir. I believe I heard you say that you were currently processing 30,000 claims a week on a population of 84,000 covered lives.

MR. BARNHILL: That's my understanding. Jim Puckett can correct me if I'm wrong, which --

MS. ERICKSON: He stepped out.

MR. DAVIS: You lost your lifeline.

MR. BARNHILL: But I can get that information from him. Does that sound not correct?

MR. HIPPLER: That's a lot of cases. From a medical perspective, that sounds -- that's normal?

MR. MORGAN: That's humongous. That's humongous.

MR. BARNHILL: It may be incorrect, and so I'll go back and ensure that the information that I have and that I've disseminated to other groups besides yours is correct.

MR. MORGAN: Well, is that for everyone you insure, or just head of household, and then they may have four, three dependents, or two dependents?

MR. BARNHILL: Well, our covered lives is 84,000 total.

MR. MORGAN: Wow. Isn't that a lot, Jeff?

MR. BARNHILL: I can tell you that the scripts -- so scripts, as of January -- because got a lot of noise in the month of January on processing scripts. There were, I believe, 80,000 scripts processed by January 22nd. 80,000. And that doesn't include medical care. So do we have a high-utilizing population? You know, I -- here's what I'd like to do. I'm going to go back and get

confirmation. I'd like to come back to you and have you guys give me what your baselines are and what you think is more normal, because I'd like to understand that.

MR. DAVIS: The population is so heavily retiree-oriented that I wouldn't have any numbers that would be comparable, but it does sound like a lot.

CHAIRMAN HURLBURT: The utilization is higher with seniors; but, overall, when we've looked at utilization in terms of comparing it to the rest of the united States, it doesn't seem to be a dominant issue here. The problem is lack of medical management.

MR. BARNHILL: But I appreciate the questions. I'll definitely take that back just to, number one, ensure that the information that I'm disseminating to various groups is absolutely correct.

MR. KELLER: Well, there would be a number of claims for every doctor visit, for every hospital visit; but it could be we're -- you know, it just occurred to me we could be talking about scripts, et cetera.

MR. BARNHILL: That's a good point.

CHAIRMAN HURLBURT: Okay. Allen, just a quick one, and then we'd better move along.

MR. HIPPLER: Another follow-up question, sir. You mentioned moving to increased network utilization as a potential cost control. My understanding was that, if you're a State of Alaska employee who is retired, you have this contract for health care, and we can't -- the state can't unilaterally change it and force them to increase network utilization, because that would impact -- that would impact, in a negative way, their benefit. I would be mistaken. Could you explain that? Could you explain that to me?

MR. BARNHILL: Sure. So the retiree plan, which is pension benefits and health benefits, is protected by the diminishment clause in the Alaska Constitution; so we cannot diminish pension or health benefits.

The Alaska Supreme Court last considered diminishment in the health care context in 2003. And essentially what the Alaska Supreme Court said was that the plan administrator, which is the Commissioner of the Department of Administration, can make changes to coverage in the health plan and can make reductions to coverage in

the retiree health plan. Any reductions in coverage need to be offset by enhancements in coverage so that the net impact to the retiree is a wash or there's a benefit.

Now, the Supreme Court hasn't considered whether network steerage or network utilization is a diminishment or not. We can see that there are absolutely benefits that can accrue to our retirees through higher utilization, network utilization. Elimination of balance bills, for one, is huge.

Now, here we're talking primarily about the under-65 population. Over 65, most of our retirees are in Medicare. We have a small population that is not. We are concerned about the extent of the Medicare network particularly in Anchorage; and we definitely have a vested interest, both for our members and for the plan, in ensuring that there are adequate Medicare network options for our members.

But talking about the under-65 population, there is, in our view, a decided benefit to accessing network options, primarily to eliminate the balance bill, primarily to eliminate those surprises that happen when you go out of

network.

So I can see arguments being made on both sides, and they have been. I mean, we have met, as I've said, over the past few weeks with literally hundreds of retirees; and there is a dynamic -- and I expressed this yesterday in committee -- in our employee population and also in our retiree population, and it's a legitimate dynamic, that government shouldn't tell people how to live their lives. Government should not tell people where to seek care. Government should not, you know, be Big Brother. And so, you know, some of these steerage mechanisms are perceived -- and I'm being candid about this -- as unnecessary government involvement in people's personal lives.

The flip side of that is, when you've got, you know, a portion of your population that is essentially procuring care in an unmanaged way, that drives costs. In our retiree dental plan, which they're paying for, when you've got a portion of that population that is procuring dental care in an unmanaged way, they're spreading costs to the other retirees. So if you've got a population in a particular location that is seeing dentists who are charging twice what everyone else

is charging for cavities, all the retirees are being impacted by that.

It's the same for the medical side of the retiree plan. When you've got retirees that are seeking care in an unmanaged way, and there are quality alternatives that are just as good, perhaps better, for the retirees that are cheaper -- and you folks know there is no lack of studies out there that show that quality really isn't correlated with cost in medical care -- that imposes costs to the State of Alaska as a whole. So we have a $3.8 billion unfunded liability associated with the retiree health care plan. That's, on a per capita basis for the State of Alaska, over $5,000 per person.

So we think there are legitimate reasons to have this discussion with retirees about network utilization and increasing that. I do not think it's a diminishment. I do think that it's something that we can do. We haven't done it except in the transplant context and except in the expanding precertification context, but we do think that we can improve care and decrease costs through the network, and that is not intervention.

MR. DAVIS: And by having a broader

network, you just automatically get increased network utilization accidentally.

MR. BARNHILL: And that's absolutely part of what we are about.

CHAIRMAN HURLBURT: We'd probably better get on. In many ways, Mike Barnhill is sitting in a warmer seat than Margaret is. Not quite as big in dollar amount, but a very politically active clientele that you serve --

MR. BARNHILL: It is.

CHAIRMAN HURLBURT: -- and we really appreciate what you do there.

Mike Monagle has met with us before a couple of times with workers' comp, where Alaska pays more than anybody in the country with high medical care costs. And other states do a way better job than we do of getting folks back to work, which, at least in my mind, is the definition of success for a workers' comp program.

Mike has become very knowledgeable about what other states are doing and the successes they've had and has been working to try to improve things here. And so we appreciate your being with us, Mike. And if we run a little bit over, that's okay. I don't see lunch here yet.

MR. MONAGLE: Okay. I'll speak fast.

CHAIRMAN HURLBURT: If we need to run a little over, I think we'll be okay, because we're not real tight on time.

MR. MONAGLE: I appreciate the opportunity to be here today and talk to you. Like the previous speakers, I find a lot of parallel efforts taking place with the Department of Administration and with the Department of Health and Social Services. And, in general, a lot of the recommendations, the core strategy and recommendations that this committee has made, is really something, on the workers' comp side, that parallels general health.

What distinguishes workers' comp a little bit is that there is no skin in the game for the injured worker as far as the cost involved. There is no co-pay, there is no percentage of premium. The cost of care is exclusively borne by the employer, so there is less incentive for the injured worker to really shop for care or be concerned about price or be concerned about quality.

Under the Alaska statute, it does

say that an employer can enter into negotiated networks but cannot steer the workers toward that network; so it's kind of toothless, and it's ineffective.

But in looking at the core strategies, the evidence-based medicine is something that states around the country have started to really adopt. I think right now there are close to 20 states that have mandated some type of evidence-based medicine.

There are two vendors out there that are, in workers' comp, anyway, the big players. One is the Occupational Disability Guide, ODG, that's put out by the Work Loss Data Institute. And the other one is the ACOM, American College of Occupational Medicine. Guidelines are put out by the Reed Group. And then a number of states have adopted their own guidelines through their own medical staffs. States like Colorado is probably the Cadillac that most people look at.

But evidence-based medicine, when we've brought it up, tends to be resisted. And I don't know if that's because of the lack of understanding. The common pushback term I get a lot is "cookbook medicine." Doctors don't want to

be told what treatment they need to provide. But I think, like Mike had indicated and Margaret, it's not about denying the injured worker treatment; it's about using conservative treatment, trying to come up with a more effective method of treatment.

And what states have done with that, in most cases, is to put in guidelines but then allow some option for the doctor to present their case to the regulatory body as to why a particular treatment should go ahead and proceed, even though a particular guideline might not recommend it.

And one typical procedure right now that's under a lot of discussion about the necessity is the medical insertion of a spinal stimulator. It's an expensive process. It's, in comp, anyway, about $15,000; and there's a lot of literature suggesting that it may not have the type of effect that the patient believes it's going to have. So certainly for evidence-based medicine, that is something that is a popular item amongst states, and it has grown.

Mike had mentioned the need for medical expertise. We struggled with that ourselves. Up until about 2009, countrywide,

medical was really the smaller part of claims. Since then, countrywide, that's grown. In Alaska it's -- 75 cents of every dollar spent on comp is medical. Countrywide, that's about 55 cents. For Alaska, the average cost of medical treatment on a time loss claim is about $55,000. That's about $27,000 countrywide.

And at one conference I was at, the comment was made, "If you're not addressing medical costs in the claim system, you're missing the boat today, because that's where the dollars are."

We don't have, in the Division of Workers' Comp, any medical expert. We have no doctors. We have no contracts. We have attorneys who adjudicate cases. And a lot of times, particularly the most expensive claims tend to be those that have complex medical issues.

So we tend to see my staff, the chief of adjudications and my hearing officers, struggle with complex medical questions. And unfortunately, a lot of times those involve independent medical evaluators, which can drive up claim costs, because there are no limitations in the system on getting referrals to medical experts.

I've seen cases that have had as much as 20 doctors on each side of a case; so every time you refer to a case and you are incurring those medical costs, legal fees would also apply. I think Elizabeth had the term -- or, excuse me -- Margaret used the term "super-utilizers." We have those cases that are small in number but very large in costs.

Price transparency is an ongoing issue in comp, getting good data on costs, on procedures. The National Council on Compensation Insurance, which is the organization that makes insurance rate-setting recommendations, recognized, a number of years ago, the lack of good data.

So, working with insurance companies, they started doing medical data collection in 2010. Their level of data they can now provide us can be drilled down to procedure codes, and it has been very helpful to us to start identifying costs. The only problem there is that about 80 percent of the market up here is in the insurance market. 20 percent of covered lives are in the self-insureds, and the self-insureds don't report any data to any government body; so there is a big pool of information out there that we lack

data on.

In talking about payment structures and redesigning payment systems, there is a big shift to electronic payment; and the Affordable Care Act, I think, has a preference for electronic payment. We don't -- in comp, we're very paper-oriented still, particularly in payment. There's national initiatives. We are a member of the International Association of Industrial Accident Boards and Commissions. They have developed payment guidelines for electronic medical bill pay. That initiative is a couple years old, and there are several states now that have participated with that.

Increased employer participation -- Mike talked about wellness programs. Wellness programs certainly can have an impact in workers' comp as well because comorbidities in workers' comp are huge cost-drivers. We are an aging population. We tend to be obese. We tend to influences of diabetes. And under the workers' comp law, it says that a claim is compensable if the employment is the substantial factor in the person's condition.

Oftentimes, you know, if I hurt

myself or I get ill at work, is it because of the work, or is it because of the comorbidity or preexisting condition? For example, a case where a person is delivering home fuel to the home, but the tank is around the back; and so they have to drag this heavy hose through two and a half, three feet of snow. And by the time they get to the back tank, the employee keels over and dies of a heart attack. Is it because of the job, or is it because he's 150 pounds overweight and has high blood pressure? Is that a compensable claim under workers' comp or not? These become very complex. They are litigated very heavily, as you can imagine. So comorbid conditions drive costs.

Again, the opioid epidemic -- there's a lot of discussion on limiting the use of the opioids. The Centers for Disease Control has called that a national epidemic.

Under the efficiency and quality of primary care, one thing that we see lacking in workers' comp is a real lack of occupational medicine training. Doctors, for the most part, are not trained in occupational medicine. They don't know the right questions to ask or how to evaluate an injured worker. So oftentimes the worker will

come in, and they're not asking what are the physical demands at work, what kind of functional capacity do you have. They are, as in general health, more inclined to say, "Well, take four weeks off. We'll see you in four weeks and see how you progress." You know, what they don't ask is, "Well, are you limited on being able to return to work? Can you perform the functions of your job?" So there is a need to address that issue.

We have a real lack of medical expertise in Alaska. When there are disputes and somebody wants to get a referral to a medical expert, typically we're sending people out of state for that medical expertise.

And these IMEs are very expensive. They can be up to $20,000 per exam, depending on the medical expert. We've had cases where we've had to send people to Hawaii, to Florida, to other states to get a particular medical expert to evaluate somebody. So it's a very expensive thing. There's always -- the complaints I get are whether this particular doctor is the insurance company's doctor or whether they are the plaintiff's lawyer's doctor. So there is always that question about fair and impartial. I'm sure you probably saw in

the news in the last couple of weeks about the doctor in Washington state who was testifying on issues when he was actually being paid by an industrial rep. So those questions creep in about, you know, impartiality.

Skipping on down towards sustainable health, as Mike noted, nobody is saying in the workers' comp system that we want to reduce the quality of care. We want injured workers to have access to quality care locally where possible.

The rub comes when we start price comparing, and we look at fee schedules in Alaska, and we start looking at fee schedules in Washington, Oregon, Idaho, and Montana. And we see that the charges, the allowable charges in Alaska, are up to 400, 500 percent higher here than they are in those other states. And so part of the discussions and reform efforts have been to address these fee schedules and medical costs.

Quickly, on the question of evidence-based treatment guidelines, we have no legislation. It's been a topic, but nothing specifically addressing that issue.

There is legislation introduced in House Bill 377 dealing with the repackaging of

pharmaceuticals. That's the practice of a doctor, typically working with a vendor, who takes drugs in large quantities, repackages them, and dispenses from their office. Oftentimes a pill that might cost you $1 down the street at the retail pharmacy, through the repackaging in a doctor's office, might cost you $8 to $10. So we're seeing, you know, sometimes 2,000 percent markups. These practices are actually being promoted to doctors as profit centers within their practice, so a number of states are trying to deal with that. House Bill 377 addresses that question.

On the use of opioid narcotics, again, the CDC has called this a national epidemic. There is a bill, House Bill 370, that attempts to limit the use and prescription of opiates in Alaska.

We have another bill, House Bill 141, which limits out-of-state treatment to fee schedules where that treatment was provided. Under our existing structure, if a doctor treats you in Washington, he could bill under the Alaska -- to the maximum allowance under the Alaska fee schedule. So this bill would say, no, it should be paid under the fee schedules in Washington state.

And then we have House Bill 316, which would change our methodology to produce our fee schedules from a 90th percentile usual and customary to a resource-based system using the CMS guidelines for the physician fee schedule, acute care hospitals, ambulatory surgical centers, and outpatient centers, air ambulance fees, durable medical equipment, and prescription drugs; and then also adopts a host of national guidelines such as the Correct Coding Initiative and other guidelines out there for billing purposes.

CHAIRMAN HURLBURT: Mike, on the 75 percent of the workers' comp costs that go for medical care, what's the approximate dollar amount on that?

MR. MONAGLE: The total dollar amount?

CHAIRMAN HURLBURT: Yeah, the 75 percent that's medical.

MR. MONAGLE: The workers' comp system in 2012 is the most recent data that I've got, and there was $276 million in total benefits in paid out.

CHAIRMAN HURLBURT: So it's three-quarters of that, then?

MR. MONAGLE: Yeah.
CHAIRMAN HURLBURT: Okay.
MR. MONAGLE: And actually, you know, over the last 15 years, statewide employment has gone up 100,000. The number of injuries in the workers' comp system have actually decreased from 30,000 to less than 20,000. So we have employment going up. We have frequency, the number of injuries, going down. So intuitively you would look at that and say, well, you would think costs were going down; but they're not.
CHAIRMAN HURLBURT: Yeah.
MR. MONAGLE: They have been going up.
CHAIRMAN HURLBURT: So you've got over $200 million then in medical care costs.
MR. MONAGLE: Yes.
CHAIRMAN HURLBURT: And I would say -- and I'll ask you, Jeff, to disagree if I'm wrong, because I'm pretty sure I'm not, but I might be -- but if you had -- you know, you wouldn't be a huge health plan if you had a $200 million budget. But it's not insignificant, and you wouldn't dream of trying to have a health plan with a $200 million budget in which you didn't have medical management.

MR. MONAGLE: Right. Correct.
CHAIRMAN HURLBURT: It would be -- you know, unless you just desperately wanted to go into bankruptcy, you wouldn't do that.
MR. DAVIS: You wouldn't have a $200 million health plan unless you wanted to go into bankruptcy. But you would also have medical management. Yes.
CHAIRMAN HURLBURT: And so, you know, in some ways, when you, in your position, talk about medical management, then your boss or the legislature or somebody will say, "Well, that's an added cost, and we're not in an environment we can do that."
But I don't see how you can conceivably -- you know, I think what I'm saying is, you are doing a yeoman's job, but you didn't go to medical school.
MR. MONAGLE: No, I didn't go to medical school.
CHAIRMAN HURLBURT: And you're probably doing --
MR. MONAGLE: I can probably share that with Mike, in that that's, you know, not my expertise; but we are forced into these

situations --

CHAIRMAN HURLBURT: Right. Exactly.

MR. MONAGLE: -- because it is a huge cost for the state. It's a huge cost for the employers.

CHAIRMAN HURLBURT: Yes.

David?

MR. MORGAN: Just a hint. I got a section of contract health where I worked, mainly because it was a small unit. It went from 400,000 and then, over two years, got up above 1 million. And since my first job out of the military was working for an HMO -- not that I'm a great medical expert; I'm a simple economist. I happen to have on staff a certified auditor of certified coding. Basically they were a certified coder but then went through the next year and got the certificate and the training and passed the test as an auditor of certified coders, recognized.

And simply enforcing a few rules about not being asked for ER rooms, which had been going on, that bill went from -- just reviewing coding, went from a little over $1 million to $600,000 in a year.

So, I mean, sometimes how you code -- you don't necessarily have to accept the way they're coded. We all have the right to review. And I didn't review all of them; I reviewed the high-cost, high-utilization coding that is going on. There are things you can do that actually don't affect what people get or even what you're paying for, just simply are you paying for the right stuff. And I don't know if you go through that review or not.

MR. MONAGLE: We don't. I mean, the state itself is self-insured for workers' comp. So the risk management, Division of Risk Management, handles that.

MR. MORGAN: Do you guys have somebody who audits the coding, who is certified to audit the coding?

MR. MONAGLE: They do. They hire bill review people, yes.

MR. MORGAN: No, that's not -- no. Do you have an auditor, a certified auditor of coding, who is certified to code -- do you understand what I'm getting at?

MR. MONAGLE: I do.

MR. MORGAN: It's like a forensic

accounting of coding. Do you have one of those?
MR. BARNHILL: I have no idea, but I've written it down and put it a star by it.
CHAIRMAN HURLBURT: But that's important, because Alex and Lydia and I -- and Alex is the only one in clinical practice now. But I'm sure Lydia and I, as well as Alex, continue to get e-mails of, you know, "Come take our webinar" or "Come to our meeting. We will tell you how to increase your collections by coding."
MR. MORGAN: So it's not --
CHAIRMAN HURLBURT: I'm totally agreeing with you there.
MR. MORGAN: And I don't know if you belong to my professional organization, which now that I'm retired, I get free. I'm a -- after 30 years of being in HFMA and certified in HFMA. And this is our periodical for health care finance, health care economics for hospitals.
And the main article is "Innovations in Cost Management." And underneath it, there's 20 pages of how to reduce outlier costs, and then there is another -- and it's detailed with studies and graphs, stuff that most of the people in the back should stay on their

phones doing stuff.

But the one I like, which I looked at this morning, was "Using Business Intelligence to Reduce the Cost of Care." And I was going to ask Ms. Brodie -- I might send -- give this to Deb. I don't know. Sometimes the professional organizations, it's sort of -- when I was in the Army, one of my jobs was how does a Russian platoon leader -- that's how old I am -- how does a Russian platoon leader or company think about what they do in combat or even can they orient maps?

I mean, it sounds silly, but maybe you might want to look at this, because these are the guys you're going to -- I used to be the guy that used to sit over here, trying to figure out how to extract -- you can ask Commissioner Streur. I've extracted $100 million, over the course of my career, from Medicaid and insurance companies. So maybe having an idea of what they're looking at might give you some clues on what you might want to look at.

I don't know. Do you guys belong to this or --

MR. BARNHILL: No, I don't, but I'm pretty sure there's one or more people sitting

behind me saying I ought to subscribe to this.
MR. MORGAN: There you go. I'll give that to you guys --
MR. BARNHILL: Thank you.
MR. MORGAN: And please share with Ms. Brodie, if she isn't a member.
CHAIRMAN HURLBURT: So in some ways it feels like we're, in the management of our health care costs, a little bit like I remember what it used to be with football games up here.
MR. MORGAN: Yes.
CHAIRMAN HURLBURT: They came on the television two weeks after the game down in America. So we really -- which means we have incredible opportunities to address the leveling of the costs and reducing of the costs and improving quality.
MR. BARNHILL: And I didn't address workers' comp costs. We do manage those for the State of Alaska. Our workers' comp medical costs are a tiny sliver of the $600 million that we spend for employees and retirees, but we do monitor them.
And so, consistent with what Mr. Monagle said, our incidence of workers' comp claimants has been absolutely flat for the last

several years, but the cost trend has been a steady 11 percent per year uptick. Incredible. Which tells me that -- you know, sometimes the medical economy has been likened to a balloon. Someone squeezing somewhere -- Medicaid, Medicare -- and it's coming out somewhere else. It appears to be coming out in workers' comp and in our claims as well. So . . .

MR. MONAGLE: I know the State of Illinois implemented a rather severe fee schedule, and I think the Workers' Comp Research Institute came out with an analysis. And costs, fee schedule costs, were down over 33 percent, but overall costs increased by about 15 percent. And what happened was a huge spike in utilization.

So, you know, I always refer to it as sort of a game of whack-a-mole. You know, if we see that -- if you try to put pressure down here -- the balloon is a good analogy as well -- it pops up somewhere else.

CHAIRMAN HURLBURT: That's kind of like some of the articles I've read, where there's only so much you can control. With more providers, more services, rates go down and utilization goes up. It's a unique economic model.

MR. MORGAN: I see we're on the cusp of transitioning into ICD-10.

MR. MONAGLE: Yes.

MR. MORGAN: And what's another factor that does happen -- not necessarily spikes in utilization, but for the last two years, I've had a former staff who was going to HFMA, American Coder Association, on how to master the ICD-10 and to blunt -- it should reduce overall costs by coding more exactly. Instead of having 7,000 or 8,000 codes, going to 40,000. Therefore, you're getting a more exact code of what's going on instead of broad ranges.

Providers hate this concept because -- not because they just hate change, but they are -- they have to refine their abilities, through their coding establishment, to meet that and do it.

But I'm telling you, for the last two years, I have had staff who went through sessions on how to take that and use that to your advantage to increase reimbursement under the new system.

So it's almost like spy versus spy. While they're -- you may think you're

changing to something that's going to help you control costs or capture outliers, it's a free, open, capitalistic system; and they're working to blunt that and, like judo, turn it to their favor to collect more reimbursement.

So which means, in this arm race, if you guys are going to do what you got to do, you're going to have to do some stuff to be prepared. You got to know what the Russian Army lets captains understand on how to orient a map on the battlefield. By the way, they don't give them maps -- they didn't then. They were afraid they'd defect. That's before the wall went down.

So, you know, it's a tough -- this is the hardest, toughest, most earnest thing I have been connected to for the broad range of quality care. And it takes years, and you have to have staff trained to do it, for certified coders and auditors of coders.

But, I mean, come on. Workers' comp doesn't have a Dr. Hurlburt to help them --

MR. DAVIS: Well, they're using you.

CHAIRMAN HURLBURT: It can't be just a doctor. You also need --

MR. MORGAN: Well, but it's more than that, but -- come on, now. They didn't even have a doctor. Believe me, the groups they're going up to have docs; guys like me, economists; analysts. For every lawyer you got, they got nine, probably.

I'm just saying, you're in the fight of your life, and you're going to have to -- if you want to win this one, you're going to have to play, and you're going to have to develop the tools to do it.

CHAIRMAN HURLBURT: We'd probably better break for lunch.

Mike and Mike, thank you so much. If you have time, there's going to be enough lunch. Please join us. I'd like the folks in the back -- if you can maybe let the members of the commission get lunch first, just so we can get it and get back on time; but there should be enough lunch for everybody.

12:18 PM

(Off record.)

12:59 PM

CHAIRMAN HURLBURT: We can maybe come back together again. And for those of us who are still eating, feel free to continue to eat your

lunch. And if you missed desert and are doing desert, there's -- feel free to get some. But let's come back together.

We have two folks here in the room who signed up to talk. And if anybody is on line, and because our system is different -- I'm not sure. We'll have the two folks here in the room talk first and then open it up for anyone on line during this --

MS. ERICKSON: Barb is trying to figure out how to unmute the phone system since we're using a different system than we normally do.

CHAIRMAN HURLBURT: Okay.

MS. ERICKSON: So we may or may not be able to take public testimony by phone.

CHAIRMAN HURLBURT: So we'll try. For anybody on line, we will try to get it unmuted; but we don't have our normal system here.

So the first individual signed up is Representative Paul Seaton. If you want to come up to the end of the table, Representative Seaton.

And there is a bill here and a sponsor statement that I will pass around that Representative Seaton brought with him for us. We appreciate your coming, and we appreciate your

interest in health, not only for your constituents, but for all Alaskans. And so please go ahead, Representative Seaton.

PUBLIC COMMENT PERIOD
PUBLIC COMMENT BY REPRESENTATIVE SEATON

REPRESENTATIVE SEATON: Well, thank you. I appreciate you having public testimony on the subject of, you know, how the state can participate in health.

This bill that we have before you here that is coming around was just in our -- we just had our first hearing with Chair Wes Keller this morning. And what we're doing in here is trying to establish in statute a Wellness Committee that would be very similar to the Citizens Review Committee that works with the Office of Children's Services statutorily there. They make recommendations, and then the commissioner has to respond within six months to how they're addressing and implementing those topics.

And the reason that I really got involved in this part of it is that we have this huge unfunded liability for the retiree section,

and that relates to about $3.8 billion. Of that, roughly $15 million is directly related to the escalating cost of health care in the actuarial analysis. And that's the amount above the 2 percent which, in 2004, when we revamped, started revamping the system, was considered to out-year, long-term escalation.

And so the goal of this bill is, first of all, to establish a Wellness Committee, but then also to give the Department of Administration a statutory responsibility. And if you look on page 2 -- and I'll just read it, so if somebody is online, they'll know what we're talking about.

Under Section 2, "To the greatest extent legally and reasonably practicable, the Department of Administration shall work to hold the escalation of health care costs to less than 2 percent annually by administering policies of group health insurance obtained under this subsection in a manner that is likely to reduce the incidence of disease in the state's population and that facilitates implementation of the recommendations of the Advisory Committee on Wellness established under this bill."

So what we're looking at is saying, "There is no way that we can continue like we are in just saying, 'How do we pay for sick care?' We're going to have to go back and look at different ways for people to stay healthy and avoid those costs entirely, instead of just looking at constraining what we pay people for providing care."

And there's a couple of the handouts that we had this morning, packets, and you're welcome to have those and pass them around. I should have made enough for --

MR. MORGAN: I was at the hearing yesterday, so I got your package already. Thanks.

REPRESENTATIVE SEATON: Anyway, we're looking at the recent scientific data that are, you know, peer-reviewed. It doesn't matter whether it's in pediatrics or -- you know, in national and international publications. And we've now got clinical trials showing that we can -- somewhere between 80 and 90 percent of Type 2 diabetes could be avoided with just vitamin D.

And this is an example that I'm using. I'm not saying that this is the only thing that we should be doing, but an example of putting

scientific studies into action is something that hopefully is what we're calling for in here.

And so this calls on the Department of Administration to do that, whether it's in contracts, when they're negotiating contracts, or they're negotiating paying for long-term health care facilities, we know we've got international and national data that shows that if people in long-term care have good vitamin D levels, you reduce the number of falls and hip fractures by 30 to 40 percent.

I mean, we're not just grabbing numbers out; we're looking now at the data that shows that if you have associated nonmelanoma skin cancers, that reduces the risk of Alzheimer's disease by about 79 percent. And, of course, nonmelanoma skin cancers are associated with a lot of sun exposure, which also gives good levels of vitamin D. So not exactly direct, but pretty direct.

So just looking at some of those things, we can see where we can, in our population, avoid a whole lot of costs. And this is in the state workforce. We're also responsible for inmates. Just this last week, a study came out,

looking at inmates in Massachusetts. Very low levels of vitamin D.

We need some nutritional standards that are for wellness in all of the facilities that we control, where we have people, where we're paying for people. And so we have a relationship where we're doing those things, so we can talk to the facilities and say, "You know, one of the conditions of us putting patients here is that you'll give them adequate nutrition."

And when we define "adequate nutrition" like the Endocrine Society or the Cystic Fibrosis Foundation or something, we're talking about 30 nanograms plus. Our national average is 21.

And so we've got national standards. We've got European standards that have just been adopted. We've got the data that's showing 40 to 60 nanograms per milliliter is where we start getting the soft tissue benefits, whether it's breast cancer, colon cancer, or Alzheimer's, brain, autism, those kind of things.

So there's a lot of studies that are coming out that are just showing that, when we only look at bone health, which was the IMO's

recommendation, it's not enough for the soft tissues.

So, you know, I'm not trying to do something philosophical; just make sure that we implement science, and that we, as a state, work with the state departments in getting us moving in a direction that will save not only costs but also the health of our citizens.

So that's what I wanted to come over and testify to, since we just had the bill. And here's one more copy in case somebody needs it. I'd be happy to answer any questions.

CHAIRMAN HURLBURT: I know you have to leave, but are there any questions for Representative Seaton?

MS. ENNIS: Is there another state that has implemented something similar and has results to share with us?

REPRESENTATIVE SEATON: There is a program in South Carolina where they have been working with pregnant mothers. And, you know, the March of Dimes has a national goal for 2020 to reduce preterm births to 9.6 percent. They have already reduced them to 7 percent with just vitamin D down there in an eight-year project sponsored by

the National Institute of Health.

So we have that data. We've got a lot of data that are coming out of the University of California, University of Nebraska. There's lots of studies that are done. And, you know, of course, we're on the edge.

The problem is, when the Institute of Medicine or the U.S. government's Preventive Task Force makes a recommendation, they make that singular recommendation for south Florida and Alaska. And when we're talking vitamin D, which is a hormone that's created in the skin from sun exposure, we're not the same. But that's where the recommendation is: One size fits all.

And so we can wait for the federal government to come in and say what's a different size, and they did. They have just increased from 400 to 600 and to 800 milligrams for a daily dose. But everyone metabolites vitamin D differently, so it's really what your serum content is.

And study after study after study is showing that 30 is a bare minimum. And you get 50 to 60 percent less upper respiratory tract infections if you have above 30 nanograms per milliliter. I mean, just one study after another,

just -- a Canadian study came out the same way.
But the soft tissues -- Europe has just adopted 40 to 60 nanograms. That's what is being proposed up here. And that's what most of the studies are coming out with. There's a study out of India that shows that you can eliminate 80 percent of gingivitis inflammation by getting up to 50 nanograms per milliliter. And that was accomplished, versus placebo, within three months; so these are short-term goals.
And the long clinical trial that was done out of San Diego when that whole group, 2,200 people, got theirs up to an average of 48, that's where they eliminated 90 percent of the incidence of Type 2 diabetes.
So has a state, per se, gone and done that as a whole state? No. I'm hoping that us, as the northern-most state who is most affected, takes the lead and starts doing that.
MS. ENNIS: All right. Thank you.
MR. CAMPBELL: Is there a fiscal note on this for the state, or is this going to be pointed down to each individual consumer through some cost?
REPRESENTATIVE SEATON: Well, when

we're looking at the fiscal cost, it is an interesting perspective, because it costs about $10 per person per year to get adequate vitamin D; so the expense is pretty minimal. If you just look at those 500 births, which were preventing about 25 preterm births, that saves $1.3 million just right there, if -- none of them are the very preterm births; that's just preterm births.

So the cost and benefits are huge. Where we're most -- the state of Alaska and lots of municipalities are self-insured, so the savings are going to accrue to them.

So, anyway, there is no real fiscal note in establishing a Wellness Committee. The Wellness Committee, as you can see in here, is a minimum of seven members. They are, you know, selected from within the department. They make those recommendations.

The difference is that you have a Wellness Committee now, but it's not statutorily defined; and there is no requirement that anybody does something with it, reports back. We just found, in HSS Committee, that the children advocacy -- or the Citizens Advocacy Committee came and reported to us, and the administration was

there, because they had to follow up and tell us how they're implementing things. So there is a statutory requirement, and so that's where you get movement.

I mean, we can talk about lifestyle changes. Those are really tough to do, I mean, as you all know. I mean, when you tell somebody, "Lose 20 percent of your weight and, you know, go from being sedentary to being an active tennis player," you know, it's tough to get those things accomplished.

So, you know, hopefully we can look at other solutions as well. I mean, I don't know anyone that currently says that Alaskans have adequate nutrition as far as vitamin D goes. I mean, there is always something -- when smoking was being banned, there was always some study that would come out and say, "Smoking doesn't hurt you."

You know, I mean, there's -- whether you believe in global warming or not, there's always some people that say, "Well, you know, carbon dioxide in the air really is going to be beneficial to us."

I haven't seen a single study that said that, you know, vitamin D is harmful. The

dosage -- there's never been a documented case of toxicity, vitamin D toxicity, at less than 30,000 IU per day. So there is a huge margin between, you know, where we are at 5,000 a day, which gets the majority of people into that 40 to 50 range, and where you get toxicity.

There was a concern for a while on kidney stones, and there has just been a study -- 4,500 people, a six-year look at that as far as kidney stones, and there was absolutely no correlation at all. No trend, even, in more kidney stones with higher doses of vitamin D, those getting up into less than 100 nanograms per milliliter.

So there has been -- you know, there is a lot of scientific data coming out. I don't know if that quite answers your question. I'd be happy to provide any other information that anybody wants on -- you know, we've got a huge stack of research papers that have been coming out on individual diseases -- like I say, everything from autism to Alzheimer's. And I'd be happy to share any specific items that you care to hear.

MR. HIPPLER: Representative, these wellness initiatives would be just targeted for

people who are covered under state-run health care plans?

REPRESENTATIVE SEATON: What we can control at this point in time is, the Department of Administration would look at the active and the retirees. There are about 17,000 active members and their dependents, and there is about 65,000 retirees and dependents. So that's where we have the critical mass. We also have, like I said, inmates. There is also a number of employees that are covered under union retiree plans.

It was interesting that, after my presentation the other day, the guy that was actually running the camera said, "Oh, yeah. Our union has already done this," and then we were able to increase their benefits because they reduced their costs.

But that's all it's covering now. It could go -- you know, go into Medicaid; but we're not trying to do that because -- at this point in time. But I think that if we get into demonstrating, you know, 40, 50 percent less colon and breast cancer and 80, 90 percent less Type 2 diabetes, I would imagine that the Medicaid in this state will be -- I mean, it's a huge cost to us,

and we would go there immediately.

Somehow, in Alaska, we have the -- I mean, we just have this tendency. We don't believe it unless it occurs here. I mean, we've got the studies out of Australia and all over the world. You know, we've got Finland and Type 1 diabetes and an 86 percent reduction in Type 1 diabetes; but we don't believe it for us here. I mean, we need to demonstrate it here.

And so -- but demonstration projects are kind of studies, and so we're not trying to do a study here. We're not trying to do research; we're just trying to put science and research into action and into -- mold it into the efforts that we could do to make people healthy.

CHAIRMAN HURLBURT: Any other questions? Thank you very much.

REPRESENTATIVE SEATON: Thank you very much for having public testimony.

CHAIRMAN HURLBURT: Sure.

We have one other person here in the room, Kathy Craft. If you could come forward, please.

PUBLIC COMMENT BY KATHY CRAFT

MS. CRAFT: For the record, I'm Kathy Craft. I'm the director of the Alaska Health Workforce Coalition. I brought the plan, our action agenda, and the updated score card. We just met on all the 43 strategies we're working on. So that's why I put the packet together in case people wanted to go, "Okay. So you've got the score card. Why are we" -- you know, they can go deeper into what it is.

MS. ERICKSON: We included this in an earlier notebook.

MS. CRAFT: Oh, you did? Okay.

MS. ERICKSON: But they probably don't have the --

MS. CRAFT: The score card.

MS. ERICKSON: I'm sure they don't. I'm sure they don't have the current score card. So if nothing else, you all can decide if you want to take a break to get copies of the current plan.

MS. CRAFT: Well, I wanted to come before the Alaska Health Care Commission just to give you a brief update. You'll remember, in 2009, there were some pockets of health entities working

on various different Health Workforce Development recruitment and retention efforts. Those individuals -- somehow we got together, and we formed a coalition in 2009. The members of the coalition are -- we wanted to go industry and government, so we've got the Alaska State Hospital and Nursing Home Association, the Alaska Workforce Investment Board -- which is a board out of the Department of Labor and Workforce Development. We have the Alaska Behavioral Health Association, the Alaska Native Tribal Health Consortium, Alaska Primary Care Association, and the Alaska Area Health Education Centers. So those are our industry groups.

And we also have the Alaska Mental Health Trust, the University of Alaska, the Department of Labor and Workforce Development, Education and Early Development in the Department of Health and Social Services as core team members. We meet monthly.

In 2010, the Alaska Workforce Investment Board was asking for a health workforce plan. So that group got together. We drafted a plan. We presented it to the board in May of 2010. They endorsed it, as well as several other

entities. So we had the plan.

And you guys talked a lot about plans this morning, so that was interesting. So that wasn't enough. So from the plan, we knew we had to have an action agenda. So that's the smaller insert within the plan.

And the action agenda actually -- it lays out our priorities. And we came upon six high occupations that we wanted to focus on, and those were primary care providers, behavioral health clinicians, direct service workers, nurses, physical therapists, and pharmacists.

But we knew we couldn't just work on occupations that have high turnover and vacancy and retention rates; we needed to work on some systems change capacity-building. So we also focused on the health repayment and loan incident programs, training and professional development, aligning regulatory policies that impact the health workforce, engaging and preparing our Alaska youth for health careers, health workforce recruiting, and health workforce data. So basically, the action agenda focuses on those 12 priority items.

The final thing you'll find -- and again, I know that this is a short time we have --

but the coalition meets quarterly to go over the 43 strategies that we implemented to try and work towards those 12 priority items that we found. And where we are -- we just met in February. We have completed three of our items. We're ahead of schedule. Excuse me. We've completed 12. We're on track with 21. Six of them have slowed up for one reason or another, so those we are addressing. We are spending more time on those. And one we know that we set -- now we know that, when we set it, we would not meet -- and that would be setting up a registered certified nursing assistant program here in the state. So that one is one we know we won't reach.

So there is work being done. Because we're getting close, this action agenda was set up to go from 2012 to 2015. We are now working on a revision. We completed -- one of the large studies that we did over the last year and a half is the 2012 vacancy study. That study is completed now. We provided to House HSS this week on the data that was collected, both from urban and rural areas. We've done 28 presentations so far on the data that we've found through the vacancy study. And we'll be gearing up to do that again, because

we'll be conducting that every other year.

So I think with that, I think the other -- you also talked this morning about results-based accountability. We also have a document -- I didn't bring that, because that's a level of detail I didn't think this group would be that interested in. But we do -- we are tracking postsecondary enrollment and graduation rates, the professional development and training.

And why that's so important is it's the training that our licensed clinicians and our professionals need to keep their CEUs, to keep their licenses to work, so people have access to services.

We're also tracking the loan repayment program, and we also have a marketing section where we watch when we run different ads for direct service workers or for CNAs. We definitely have an increase in people who go to the website and then click into the Department of Labor's Job Center, looking for jobs. So we have a direct correlation from -- if we run ads in Pandora, we can see images and clicks and then how many people go to the Department of Labor's Job Center.

What we won't and can't find out is who then actually gets a job. That connection we can't make, but if we run it through Google, we're finding certain things, and when we run TV ads. So we are basically watching that; and we have, through the trust, some monies that we work with in marketing.

So I just wanted to provide that update and let you know that all plans don't just get shelved, that we do work on things. And we will be revising, based on the vacancy study and some other data, a new action agenda for 2016 to 2019.

CHAIRMAN HURLBURT: Thank you, Kathy. Are there questions?

David?

MR. MORGAN: This is just for my own edification, because, contrary to public opinion, there's a lot of things I don't know.

MS. ERICKSON: David, you need to speak up too.

MR. MORGAN: Thank you. That's the first time I've heard that statement in ten years.

I've been down to the legislature either for the Primary Care Association or -- you

know, several times in the last -- during this session. And one of the questions I've kind of wanted to ask, but I've never been in one of the hearings or somewhere where I could button-hole someone -- when the loan repayment program -- and I thought maybe you might know this. When the loan repayment program started, the thing that -- I cut my teeth most of the time in the rural parts of the state, like the Aleutians or places like that -- the goal was to bring providers, mid-level providers, to the rural part of the state.

MS. CRAFT: Right.

MR. MORGAN: Unless it has been added here, which it could have been, do we really have a breakdown of where the new providers have gone?

MS. CRAFT: We do. And I don't have it, but I have it where I can send it as soon as I get to my laptop today.

MR. MORGAN: I don't think it's that important to the commission; I just was nosey. I mean --

MS. CRAFT: We have a breakdown of what communities they come from -- where they're coming from, where they stay, and what fields

they're in, whether they are behavioral health clinicians or whether they are doctors. Yes.

MR. MORGAN: And where they went?

MS. CRAFT: And where they went.

MR. MORGAN: And what -- and I won't hold you to it, but what was the outcomes on the individuals financed through the added program? When was that, a couple of years ago I guess, or --

MS. CRAFT: Do you mean when HB 78 was passed?

MR. MORGAN: Oh, there was some loan repayment programs.

MS. CRAFT: Well, there is SHARP I and SHARP II.

MR. MORGAN: Yeah. SHARP II is the newer one.

MS. CRAFT: Correct.

MR. MORGAN: I was wondering, where did they go? And I don't need it that detailed. Like how many of them went into communities not on the road system, rural, and those on? Is there a -- can you remember a percentage breakdown? I was just wondering.

MS. CRAFT: I do not sit on the SHARP Advisory Committee. But I have been added,

and I will start in April -- will be my first meeting. But I've been getting the data for the last month, so I think -- I don't know the answer to that, but I think the data that I've received in the last couple of months will have it.

MR. MORGAN: It's not a big deal. It's just I'm noticing --

MS. CRAFT: No. It is important to know where --

CHAIRMAN HURLBURT: And I'm sure you have an impression, Kathy; but from what I understand, there is a little concern that a large number went to the more urban areas and not as many to the rural areas as Representative Herron had hoped.

MR. MORGAN: I was just wondering how it turned out.

CHAIRMAN HURLBURT: Do you know, Kathy? Just as far as a general impression.

MS. CRAFT: From the breakdown that I saw this week, that doesn't bear true. So that's what I'd like -- when I get back to my laptop, I can send that to Deb.

CHAIRMAN HURLBURT: Okay.

MS. CRAFT: And especially for

SHARP I. SHARP I was very rural-oriented.
CHAIRMAN HURLBURT: Yeah. SHARP II was what I was talking about.
MS. CRAFT: Yeah. And then -- but I still think the numbers are pretty good in the rural areas for SHARP II.
MR. MORGAN: Well, it's not an issue with me. I was --
MS. CRAFT: Right.
MR. MORGAN: It's just one of those little factoids I wanted to find out about. When I saw you come in, I thought, "Boy, I can ask her." You probably know, or at least know where to get the information.
MS. CRAFT: I can tell you that the loan repayment program has been, I think, a really -- not only an important recruitment tool but a retention tool for Alaska. It's been very important to have. But I will definitely get that information to Deb so she can share that with you.
MR. MORGAN: It doesn't have to be today. Just whenever.
MS. CRAFT: And the other thing I think that Deb and I did -- it's probably been a year ago -- is we took the Health Care Commission's

priorities and the priorities of Health Workforce Coalition, and we did a cross-check. We had quite a lot in common, and there was quite a lot of alignment. Where we don't focus as much is on the payment structure and cost, and so there were gaps there where we weren't -- not that we weren't in alignment; we just aren't focusing on that in the work that we're doing.

MS. ERICKSON: The same things. Yeah. One of the things we talked about a lot in terms of the infrastructure support is related to the data. And while the vacancy study is important and a huge effort, we question whether it really gives us a good picture of need, because whether there is -- the fact that there is a vacant position or not doesn't mean that --

MS. CRAFT: We usually start our presentation out saying that the vacancy study does not represent need.

MS. ERICKSON: Right.

MS. CRAFT: And that --

MS. ERICKSON: And that was part of the data development part of this plan, was: Can we get to a point where we have a better sense of what actual need is for a workforce that also appreciates

the potentially real rapid evolution in how our delivery system might be changing in the near, if not distant, future?

MS. CRAFT: We based a lot of our initial work on four issue papers that we wrote recently -- and I'm not getting too ahead of the core team, because we haven't really discussed it yet. But we are talking about -- and I've drafted our fifth issue paper on whether we can do some data collection at licensing and renewal of licensing.

Right now, we would have to work with every individual board, and I can use myself for an example. I'm a licensed professional counselor. I may be one of the 600 or 500 in the state, but I'm not an active therapist. So how many of the 500 or 600 out there are like me? Do we really only have 200 that are providing or have access to services? We don't know that.

MS. ERICKSON: And a lot of -- my sense is, a lot of other states actually will survey, through the licensing process, their professionals, so they have a better sense of --

MS. CRAFT: Yeah. So we are beginning to grapple with that. Our Health Workforce Data Group is going to get together and

talk about what we can do.
California asks 67 additional questions. We're not talking about that. We're talking about a very --
MS. ERICKSON: Just some basic --
MS. CRAFT: Yes. Like six to eight, maybe ten, you know, somewhere in there. Just really critical questions about, you know, "Are you an active professional, you know, working actively in the field?"
So that, I think, is something you'll be seeing coming out of the Health Workforce Coalition.
MS. ERICKSON: All right.
CHAIRMAN HURLBURT: Thank you, Kathy.
MR. DAVIS: Great work.
CHAIRMAN HURLBURT: Do we have access to the phone?
MS. HENDRIX: Not just yet.
MS. ERICKSON: Barb is working on that.
CHAIRMAN HURLBURT: Okay.
MS. HENDRIX: Crystal sent an e-mail about that, and then --

MS. ERICKSON: Oh. Well, we can do that letter, because we don't need this yet, Barb. We probably won't need it for at least half an hour. Our other technical gift. We love working for government.

So if there is anybody on the phone who is interested in testifying, we are working with our teleconference system.

Oh, that's promising. Are we going to get feedback from the mike?

MS. HENDRIX: They are all unmuted right now.

MS. ERICKSON: Everyone is unmuted who is on the phone. So is there anybody on the phone who is interested in testifying? And nobody is indicating on webinar, Barb, an interest?

MS. HENDRIX: No.

CHAIRMAN HURLBURT: Okay. We can go ahead, then --

MS. ERICKSON: Okay. We're going to assume that there are not. And you can go ahead and mute the line again, Barb.

CHAIRMAN HURLBURT: Let's go ahead and move on to the employer's role.

2014 STRATEGIES:
EMPLOYER'S ROLE IN HEALTH &
HEALTH CARE GROUP DISCUSSION

MS. ERICKSON: Let's start with that, but we're going to take a pretty long break to give folks a chance to do some homework, if they hadn't done it yet.

MR. DAVIS: No naming names.

MS. ERICKSON: I see you all smiling. Yeah. I'm not looking at you.

But since we have some extra time, because this is something that --

CHAIRMAN HURLBURT: Do you want to do that before we get into discussion, or after, on the employer's role? Since we didn't get to that this morning --

MS. ERICKSON: Oh, you wanted to have that part of the conversation? I figured we would just have it all together.

CHAIRMAN HURLBURT: The 2:00-to-3:00 session. Yeah.

MS. ERICKSON: So what we're looking at on the agenda is from this morning's discussion. We talked a lot about the -- go back

and look at right before our 9:45 break on the agenda. We talked a lot about the statewide health plan and potential coordination or collaboration with the Medicaid Reform Advisory Group. But we didn't get to the point where we were talking about the commission's role related to engagement with private-sector employers.

So we can talk about that a little bit right now. I have -- there are two documents in your notebooks that had been included in your homework to review and think about comments. And so what we'll do, since we're -- after being behind schedule for most of the morning, now that we're ahead of schedule a little bit, we'll take an early and kind of long break for you to either refresh your memory on those two documents or look at them for the first time if you didn't have a chance to review them before the meeting.

But let's start off with me explaining a little bit about -- one of our core strategies is to engage and support employers -- all employers in the state, not just private sector. But something that we've attempted to do over time in reaching out -- especially with Commonwealth North, but with some other business

groups -- is trying to find ways to engage employer groups.

And it was never as successful as I would have liked to have been with that until they found us. And I believe I mentioned at our last meeting that there is a group that formed just this past year, during 2013, of HR directors from some of the largest corporations in the state -- from the energy sector, transportation, banking, telecommunications. Many of the Native for-profit corporations are participating in this group, along with ConocoPhillips and BP and CH2M Hill and SolstenXP XP and Northrim Bank and GCI.

This is a group of HR directors from these private-sector employer groups that have started meeting together on a monthly basis. They call themselves the Alaska HR Leadership Network, and they convene specifically around their concerns about their ability to continue dealing with health care costs in the state from an employer's perspective.

They discovered us -- they had started working on doing -- with some benefit consulting company, trying to do some surveying for them. They set out to first see if they could

verify whether -- what they believed to be true, that prices here were higher than in other states in our region, if they could document that.

So they started out with this benefits company just surveying themselves. And then somebody found out and pointed out to them that some group called the Alaska Health Care Commission exists and already did an actuarial study comparing pricing.

So before they finished that survey, they found us. And I got a phone call maybe two or three months ago. It was probably three months ago now. They started inviting Ward and I to their monthly meetings, and they have an executive committee that meets even more frequently.

So we shared the Milliman report with them and started talking about strategies. And they were so excited about the existence of the commission and the work that we had done already. I included in your notebook some resolutions. And I was telling our commissioner the other day what a different experience it is working with folks in the private sector versus working in government. We would have taken three months just to talk about

whether this would be a good idea or not. They decided that they wanted to do things, and they are going to get things done.

So in addition to all of their strategizing, when they understood that the commission might go away sometime soon, they said, "Well, we need a resolution supporting the commission and the commission's recommendations."

So this was not a request on our part; it was their idea. And they have been circulating these resolutions that I included in your packet, that maybe a third of this group has signed off on. I think some of them are a little tentative about it because it essentially endorses all of our recommendations, not just the continuation of the commission.

And then I got a call one day just this past month, the day after an Anchorage school board meeting, and was informed that the Anchorage school board had unanimously passed a resolution supporting extension of the Health Care Commission. And I said, "Who did what?" I had no idea they even knew we existed. But they got tied in with this group. And if you haven't been following what's going on in the Anchorage school district,

as is going on in many other places, the rapid escalation in their health care costs are really squeezing their budgets.

And Mark Foster came to our last meeting and --

MR. DAVIS: All right. So Mark knows we exist.

MS. ERICKSON: -- demonstrated -- Mark knew. He was the one who got that information to them.

So that's a little -- and you can read the resolution in here. Just -- it pulls some highlights from some of the data, most current data, about how costs are impacting employers in this state, both employee benefit costs as well as workers' comp is addressed in here.

So, I mean, just to give you an example, they're talking about wanting to bring providers to the table to have conversations about costs and pricing and their charges, and they're talking about strategies about what they want to do if they won't come to the table.

So if you remember our meeting -- I'm going to be doing kind of a stream of consciousness a little bit here. Follow my brain.

Yeah.

Our October meeting that we did jointly with Commonwealth North, the woman from Tennessee -- and we just kind of wanted to plant the seed in many other states and then nationally. There are coalitions of employers that have organized, like the National coalition on Health and the National Business Group on Health, that actually works on strategies together, not just learning opportunities. And they are at community and state level.

So it's possible that this group will be a seed group for the private employer sector to launch something like that when they can start working together on strategies for improving health care cost and quality. And for now, they are looking to the work of the commission to help inform them.

Then at this -- before we knew of the existence of this group, before we had discovered each other, you'll remember we've had Gunnar Knapp, who is now the director for ISER, come and present to you a couple of times. But we are working with ISER and with the Department of Labor right now, and have been for several months,

on the study to survey employers in the state to get a sense of where they're at today.

We're actually looking at data from last summer, because we wanted to look at data in part for having a benchmark before the Affordable Care Act fully took effect in January 2014, where they are at in terms of providing coverage, and the sorts of strategies that they are employing to address some of their costs.

So I've included -- this is all behind Tab 3. I've included a copy of the survey instrument. So part of your homework assignment was to look at this survey instrument. And, of course, we have lots of ideas about what they're going to analyze from this data; but we just wanted some input from you at this point about what you think is the most critical research question, or are the top two or three research questions that we would have our analysts at ISER digging into first behind this data.

What I anticipate is not just having this as a report and some information that may or may not sit on a shelf, but that we could use the report from the survey, then, to inform continuing conversations with these employer

groups, and just starting with, "This is a report from the survey that was just done. Does this reflect your experience? Is this what's going on with you and for you right now? What are your issues?"

So in part to just inform ongoing dialogue and discussion and maybe some informal focus-group-type dialogue to see what employers are doing and how they're doing and is there -- ultimately, what I think one of the things this commission is interested in, from a state policy perspective, is, "Are there other things, beyond the things we've identified so far, that state policy creates as a barrier in some way to employers addressing their concerns, or something more the state can do to support them?"

So assuming we're extended for another three years, I think one of the roles that the commission could play is facilitating in some way and supporting in some way those employer groups and at least coming to the table with the state policy ear listening to their issues and their concerns and trying to learn from them to inform the work that we're doing, at a minimum.

So with that as background, one

other thing they asked us -- "us" being just me and Ward -- if we would do, and we haven't -- we've shared this with them, but we haven't had a meeting to review it together yet. And I just wanted to go ahead and share it with all of you.

In the back of Tab 3, this six-page -- five-page document, "Health Benefit Recommendations for Alaska Employers" -- they asked if we could give them a list of recommendations of what we think they should be doing. And so I drafted this just as a starting point, really based on the recommendations that you all had come up with that was just a shorter list of kind of the five pillars of an effective employee health benefit program, an employee health management program.

And we don't know if this is what they had in mind when they asked for recommendations, but I thought we'd go ahead and share it with you and get some feedback from you, and it will be a work in progress for some time.

And so that was part of your homework, was to read that in advance and to mark it up, tear it apart, or come back and say, "Well, we don't even think the commission should be doing

something like this." Whatever your response is -- because we are just kind of continuing to evolve as we go here. And we just want to -- if there is an opportunity to be of service and to add value for employers, since that's one of our eight core strategies is to engage and support employers in this sort of activity, how do we do that, and what's the best way to do that, and what can we learn from them?

So with all of that -- I'll give you a chance to ask questions about that in a second, but what we'll do is take a fairly long break, or at least a 15-minute break now, and then we can reconvene at 2:00.

So take a look at the survey instrument and also the five-page draft.

MR. DAVIS: Can we do 30 minutes so we can actually take a break and do homework?

MS. ERICKSON: I think we could. I think we could, because we're going to have a lot of discussion time tomorrow too.

So behind Tab 3, are you finding your -- that looks like it. Yeah. The survey is attached to letterhead from the State of Alaska Department of Labor.

I didn't mention the Department of Labor. We contracted with the Department of Labor and ISER both to collaborate together on this study. So the employer survey is being conducted by the State Department of Labor, but ISER is working with them -- worked with them on the survey design and is going to do the data analysis.

MR. PUCKETT: And that hasn't gone out yet?

MS. ERICKSON: Oh, it did.

MR. PUCKETT: Because I was going to say, how many did they get back?

MS. ERICKSON: They had, as of -- I don't remember the exact date it went out; but as of late February, they had 856 surveys back, and the sample that they're trying to gather is about 1,200.

And when I talked to them last, which was probably two weeks ago, they made more progress; but their experience with the Department of Labor, because they do this hopefully not too often, poor employers -- but they periodically, in doing surveys -- I mean, they have a lot of experience surveying employers. And they explained that, at some point, they would need to start making some phone calls and doing interviews to

gather this data to actually reach their target sample.

They broke -- they're breaking the sample down and have identified the number that they will need for a statistically reliable number into a number of different categories by employer size, in part driven by the different rules associated with the Affordable Care Act, so I think there is zero to nine or ten employees, just whatever the major cutoffs are. I'm remembering there are four or five categories -- 25 employees, 50, and 100, I think.

So they're working to gather enough data from each of those categories of employers so that they can do an analysis across different employer sizes.

Are there questions either about the HR, Alaska HR leadership network, or the survey or any of this other stuff before we take a break for about 25 minutes?

CHAIRMAN HURLBURT: Yes. Let's come back at 2:15.

1:48 PM

(Off record.)

2:19 PM

CHAIRMAN HURLBURT: We're back into our session at 2:00 today. We're talking about the employer's role, and we had the documents that looked at an hour or two before.

And, Deb, are you going to go ahead?

MS. ERICKSON: Yes. Let's start with the survey. This is -- we'll just do a little brainstorming, you know, throw out ideas of what you think are the most important things we need to learn from employers about their employee health management practices and plans for the future.

MR. DAVIS: I think this is an awesome survey. It's short, sweet, and to the point; but it hits all the really important elements of wellness and plan design and contribution and availability. That's -- yeah. That was impressive.

CHAIRMAN HURLBURT: Allen and then David.

MR. HIPPLER: Yes. I would be interested in a survey that also included questions regarding preemployment discrimination on the basis of tobacco use and, anymore, obesity.

CHAIRMAN HURLBURT: Would you accept "selection factors" rather than

"discrimination"?
MR. HIPPLER: Sure. Same thing.
CHAIRMAN HURLBURT: The information would be helpful, but I think the word "discrimination" could put a certain complexion in somebody's mind.
MR. HIPPLER: Okay.
CHAIRMAN HURLBURT: Because like travel systems utilize that now. Alaska Airlines utilizes that now, and it would be good to know that.
MS. ERICKSON: Tobacco specifically, not obesity.
CHAIRMAN HURLBURT: Tobacco, yes. Yeah. But --
MR. HIPPLER: I'm not aware of anybody officially using obesity as an employment selection factor.
CHAIRMAN HURLBURT: David?
MR. MORGAN: I was just going to say, when I looked at this last week, I had a talk with the health care insurance underwriters. They thought this was an extremely good study. They said they -- I've been trying to get them to show up to some of the meetings. They said when this comes

back, they were going to show up for this one just to see how this turned out.

CHAIRMAN HURLBURT: So that sounds like really good and really positive feedback, Deb. You and they did well.

MS. ERICKSON: And so you don't have any specific suggestions for --

CHAIRMAN HURLBURT: Just Allen's question.

MS. ERICKSON: Well, and that -- I wasn't looking for -- that's going to have to -- that information will need to come through another mechanism, unless there is a way that a question is worded here that they would identify it, but I'm not remembering. So this survey won't gather that.

MR. DAVIS: It could have, but it won't, because it wasn't there?

MS. ERICKSON: So the question is, from the data that will be gathered from this survey, are there specific research questions that we want to make sure that the analysts are addressing?

MR. DAVIS: Well, I would want to see the interview; and then I think, at that point, the questions will flow.

MS. ERICKSON: And that's what I was imagining for conversation with the employers too.

MR. DAVIS: And the researchers will probably do that too. They'll look at it and say, "Well, why does this look this way?" It's hard to know without seeing the data. I can hardly wait to see it.

MS. ERICKSON: Okay. Any other thoughts about the survey itself, what we'll do next with it?

I expect that the surveying process will be complete sometime in April and that the data will be cleaned and analyzed in April and May. And they're shooting for having the report done in June, so maybe in time -- hopefully in time for our June meeting. But if not, our August meeting.

So I'm going to go ahead and move on, then, if anybody doesn't have any other comments, questions, or suggestions about the employer survey study.

So then what did you think about this "Health Benefit Recommendations for Alaska Employers" draft paper? Be honest.

MR. PUCKETT: It would be better if I did my stuff on the electronic version and sent it back to you. But I can offer --
MS. ERICKSON: General comments?
MR. PUCKETT: I can offer, if you want to do the editing --
MS. ERICKSON: I mean, we're not -- I don't intend for us to do wordsmithing here.
MR. PUCKETT: Okay.
MS. ERICKSON: Just the concepts.
MR. PUCKETT: Good.
MS. ERICKSON: Are they -- for these top ten general recommendations, are those right on, or are they completely off base?
MR. DAVIS: I think they're -- oh, I'm sorry.
MS. ERICKSON: Go ahead.
MR. DAVIS: I think they're right on. I mean, I don't see anything major that's missed or anything that I would disagree with. I might do some wordsmithing with it.
No. 5, perhaps, is a little bit redundant because most of those elements are mentioned elsewhere. But at the same time, it does call them out as the five main elements, which is

kind of helpful, I think, to group them that way.

Let's see. There was one. So maybe the only one that I would want to debate a little is on page 5, 3c., "Advocate for state transparency laws." And all I would say is, that's really difficult to conceive of something in law that's going to really be helpful for transparency if it's too prescriptive. Transparency is really tricky to make sure it's apples-to-apples that are being compared.

And if you don't get it right, it's not helpful at all. In fact, it can lead to wrong conclusions. So I'm just not sure that it -- I think that everything else in Section 3 is great -- you know, providing informational tools, pushing providers and insurers. Absolutely. It's just I'm not sure this is a useful role for state government. But that's more of a question than a statement.

CHAIRMAN HURLBURT: And it's an important question, and I think I understand part of the concepts that you are bringing up. I've seen a recent statement that said there are 16 states now that have like an all-payer claims database, and then the total of 30 states that either have it or

are considering it.

As you know, to date I've been a little disappointed that it hasn't been utilized particularly by the public and then, kind of come to think about it, maybe also employers would be the ones that would use it. But obviously your companies come to -- and in the overall corporate structure, there are some conclusions on that.

And it's clear that it's been a part of our recommendations for the Health Care Commission, and it might be well, if we're going down a rabbit path or something, to talk about that, because our recommendations really are requests to the governor and to the legislature to do something that we think will help.

And I think you're saying maybe we should be a little cautious, that there's some potential pitfalls. So can you take off on that a little bit?

MR. DAVIS: Well, as you know, I've struggled with this whole all-payer claims database issue, because, with you, I haven't really seen it turned into actionable data. And, I guess cautiously, I would enter into saying, you know, "Let's be sure about" -- actually, we described the

process very well, I thought. You know, have the stakeholders be clear about what we're trying to do. I think those questions will get answered through that recommendation, which really isn't doing an all-payer claims database; it's take the steps that would lead to it and make the appropriate decisions along the way. So I'm fine with that.

This, I -- when I read section c., I think of things like -- and I believe this is accurate -- like states saying, "Post your top 25 prices, the prices for your top 25 things you do."

Well, in health care, that's not usually helpful. And it may be that one of Jim's covered customers is paying a different price than someone else's covered customer, so how do you deal with that? And how do you deal with the fact that "This is what I charge for a chest x-ray, but when I do a chest x-ray, I always do these other three too"? I mean, it's -- that's the difficulty in transparency.

So I wouldn't want us to go down that direction. So maybe if there's just a qualifier in c. -- you know, meaningful or actionable or something like that. It may be that I'm not -- didn't memorize it, but then that would

give us at least a razor to say, "Transparency information is tricky, and we need to be really smart about it."

If we could figure out how to do it, it would be really valuable; but if you do it wrong, it's harmful. That's what I was trying to say.

MS. ERICKSON: And we actually will have a conversation about state price transparency laws tomorrow morning.

MR. DAVIS: Okay. Great.

MS. ERICKSON: It's on the agenda.

MR. DAVIS: Great. Maybe that will help inform what, if anything, we need to do.

MS. ERICKSON: What should be included in this recommendation for the employer's role specifically?

MR. DAVIS: I think it's a great document. There's probably a few places where we are saying, "You, employer, should be doing this," and, really, it's things -- it's reminiscent of a conversation we had this morning about workers' compensation. We were like, "Wow, we don't have the expertise to do these things. They need to be done." A lot of these things have to -- there is

going to have to be a partner at the table, whether it's the health plan or TPA or the consultant. If an employer were able to do all these things, they would be -- they would be --

MS. ERICKSON: In a different business?

MR. DAVIS: They would be in a different business. Right. They'd be the State of Alaska as an employer. I mean --

MS. ERICKSON: Not running the railroad, which is one of our employers who is not --

MR. DAVIS: -- normal employers, right, don't have the expertise or the resources to do that. So it's just sometimes we switch back and forth, and it maybe could be more consistent.

Did you --

MR. PUCKETT: Well, it's unfortunate that a commission like this has to have these types of conversations on transparency laws, because that means that the consumers don't have the information they need to make those kind of decisions that they should be making on their health care.

And so as long as we keep that in

mind, I'm not advocating for government to get involved in all areas of our lives. I'm certainly -- I'm a little suspicious of government, and it's funny for me to say that since I'm working for government.

(Laughter.)

MR. PUCKETT: But I think all of us on the commission agree that it is a very personal thing; but in order for the consumer to become informed and for the dynamic of supply and demand to work, they need information, and they don't have it. And the industry in general, the health care industry in general, has failed to respond to provide that information to the people.

And so I think that we don't want to water down the state, the government having to interject itself into this because the industry has failed to do so.

MR. DAVIS: If I could just build on that. And I think this document makes -- sets up the actions that will cause that to happen. You know, it's making a recommendation here, saying, "Consider consumer-directed health plans." Okay? So we have high deductibles now. Now I have more of an incentive to want that information.

We're saying, "Push your health care insurer and your providers to provide the information, now that we have people who want it."

So I think it sets up the dynamic to get to where we think it needs to go. And I agree with you. It's sad we're not there yet, but this document describes a new world or an emerging world that would require those who are in the business of providing information to do it or be irrelevant, and it doesn't take state action to do that.

MR. PUCKETT: And when the employers, who are paying the bills, have a hard time getting the information, well, then, something is out of balance.

MR. DAVIS: Right. They should pick a new carrier.

MR. PUCKETT: What's that?

MR. DAVIS: Pick a new carrier; right? Not wait for the state to solve it.

MR. PUCKETT: Well, that's what I'm getting at.

MR. DAVIS: Yeah. I'm agreeing with you.

MR. PUCKETT: If the industry

doesn't respond, then I think the state will have to step in. It's just unfortunate that we're having that kind of conversation. We should not be having to have that kind of conversation.

MR. DAVIS: And I guess -- one last thing. What I'm seeing is, the industry is responding. It's not -- it's hard work, and we are hard at it. It's not for lack of trying. But there has been a lot of progress in this particular area, so I think you are prophetic in expressing that desire.

CHAIRMAN HURLBURT: Jim, you used -- I think not to preclude your getting back to Deb by e-mail, but maybe conceptually, while we're all together, you could -- if you had some thoughts that you could share, I think we would appreciate it.

MR. PUCKETT: I think the recommendations are very thorough. They are well done.

As a former business person with a couple of employees and out buying my own health insurance, I would have liked to have had this kind of information when I was breaking out and doing my own research. Frankly, a lot of these things here,

I didn't have a clue. And what I found out in doing a little bit of research is, I, real quickly, just went to what can I afford. I wasn't looking at different features; it was just a matter of the bottom line. So I was limited to a high-deductible health plan.

One of the things I would change is on No. 7. If you want to address this to employers, instead of "Understand Health Care Market," I think we could just -- this is a little bit of wordsmithing, but I think we just need to be more direct and say "Educate" -- you know, reword it. "As an important purchaser of health care, educate yourself to begin exploring consumerism."

Just be a little more active in what they need to do there, because that's what I found myself having to do. I had to suddenly educate myself on what was out there in the market.

CHAIRMAN HURLBURT: So you have to go out and have an active process --

MR. PUCKETT: I had to have an active process.

MR. DAVIS: -- not just sitting, waiting for divine inspiration.

MR. PUCKETT: Now, it wasn't a real

long process --

MR. DAVIS: We'd welcome it if it came; right?

(Laughter.)

MR. PUCKETT: Now, it wasn't a real long process for me personally, because I quickly found out it was just going to be a matter of what can I afford. I thought I could go out and -- like shopping for a car. Do I want to get a Chevy or a Ford? And what model?

I quickly found out, "I'm just going to see what I can afford." And so I was limited to a high-deductible-type health plan. That was all I could afford at that time.

But I think we need to address this more directly and, as an important purchaser of health care, go out and educate yourself on these items here.

But on 1 through 10, I think it's very well done.

MS. ERICKSON: Yes, Allen?

MR. HIPPLER: Item 9 is titled "Advocate for State Health Policy Improvement." While I actually like No. 9 a lot, and I agree with everything that it says, it occurs to me that this

is potentially not appropriate for a state commission to advise businesses to advocate the state to change things.

It reminds me -- this is a stretch, but I'll share with you what it reminded me of, even though it's not very similar, just so that you understand where I'm coming from.

I recall, quite a while ago, there was some hue and cry because somebody got a grant and used a portion of the grant to hire a lobbyist to go back to Juneau and lobby for more money; and that was considered inappropriate. And, to some extent -- this is not the same thing, but it's still -- where the state is telling people to tell the state to do things. So I thought I'd throw that out there.

MR. DAVIS: Well, it's a little funny. We're asking them to listen to us. That's kind of what it says.

MS. ERICKSON: Well, what we -- the way it's worded, for folks who are in the audience who don't have it in front of them, is "To work with the commission to identify and learn how to support needed improvements in state health policy."

So perhaps what we want them to do

is just to engage in the process, to understand -- we've asked them to understand or to educate themselves about health care market dynamics. Part of that is understanding the government policy environment that the health care market operates within and understand how that impacts them as employers who are purchasing health care for their employees, and to be involved in the process of setting state health policy, because it's impacting them and because they're citizens of the state, and that they need to just be involved in the process.

So maybe there is -- "advocate" probably was the wrong word to use to Allen's point. And maybe it just needs to say "educate" -- and "participate in the public process to make sure that your policy leaders understand your issues and" -- does that make more sense from a legislator's perspective?

MR. KELLER: This is a very gentle violation of that concern, compared to what I see. If you leave it the way it is, it's fine.

MS. ERICKSON: He gets to work with folks who are advocating for state policy improvement all the time.

MR. MORGAN: Maybe "engage."

MR. HIPPLER: Yes. A very small change would, in my opinion, change the tone of it and make it palatable. I mean, it's almost -- I can almost not object to this right now, but it's just that word, "advocate," and the specific way it's framed just -- it really seems to me like the state is telling people to tell the state to do things. That's all.

MS. ERICKSON: We are, though.

MR. KELLER: Well, but I would argue that we're really not the state. You know, yes, we have our good and wonderful leader, Dr. Hurlburt, and Deb; but, as look I around the table, this is not the state.

So I think that the definition of this group is in fact -- you know, it's supposed to be -- we're widely based, and I would argue that you're more representative of the people out there, because that's -- think about it. That's the point. You know, we are interested in good health for Alaskans.

MR. MORGAN: We're the health care militia.

MR. KELLER: But that isn't to take away from what you're saying. I think "advocate"

probably is the wrong word, but I just can't -- I'm not coming up with the right one.

MR. MORGAN: Interact, engage, or something like that. Get in the game. Be out there and ask us questions or . . .

MR. PUCKETT: Take the bold out and change it to "Work with the Alaska Health Care Commission," and then begin your next sentence.

MS. ERICKSON: Other suggestions?

MR. MORGAN: Be all you can be. But didn't they ask -- the work group or the --

MS. ERICKSON: The Alaska HR Leadership Network.

MR. MORGAN: Right. They asked you for something like suggestion? This was --

MS. ERICKSON: They asked for this.

MR. MORGAN: They asked for this?

MS. ERICKSON: But we haven't -- and I provided this to them, but we haven't had a meeting to discuss it yet. So I haven't -- I don't have their feedback yet, but I wanted to just go ahead and share it with you. While we're kind of feeling our way forward, what should our role evolve to? So that's one of my questions for you beyond just what feedback would you have on the document

itself, is: Is this the sort of thing you see the commission doing more of, and does this add value for the state citizenry?

MR. MORGAN: But, I mean, collaborating on a state health plan -- isn't sort of all the rules -- I mean, it almost puts us beyond this point, in my mind.

MS. ERICKSON: Well, it's so --

MR. MORGAN: Although we have no power, we can put a plan out there to jawbone. And we can't tell anybody what to do or to change what they're doing, but we have been very scrupulous over the years not to do stuff like that.

And in the bill and everywhere, we're to work on a health plan, but doesn't that kind of -- what you're talking about, kind of move us to another part of the chessboard in a way? Just compiling that document, publishing it, and putting it in a big stack out there changes our role a little. Maybe a lot.

MS. ERICKSON: Uh-huh.

MR. MORGAN: I'm not objecting; I'm just making a comment, a perspective.

MR. CAMPBELL: Considering in your statements about -- and reading what audit said,

where does this put us on that scale between only recommendations and their, as I gather, recommendation that we be a little more proactive, policywise?

MS. ERICKSON: I think this is an additional role, because what the legislative auditors were speaking to specifically was the duty for the state health department to develop a state health plan based on our recommendations.

And right now, we're really focused -- and that could evolve and expand to something more, to include other partners. And, by extension, it includes lots of partners. The state -- the different state programs that are listed in this draft plan framework right now can't implement any of those initiatives that are listed right now without engaging and collaborating with the provider community, other payers, consumers. That's part of their process. We are not doing that for them, and it's not our role.

But documenting in that plan what the state programs are going to do and how they're going to do them and by when they're going to do them and how they're going to measure whether they had the expected outcomes, desired outcomes, or not

is part of that plan.

This, providing advice, this document that would be providing advice to private-sector employers -- any employers, really. Public-sector employers as well -- isn't something that is necessarily even suggested, I don't believe, in our charge; so it's kind of going beyond that, our charge, I think. So that's part of my question.

I mean, our charge is broad enough that there is already more than we could ever possibly do, but we've tried to limit our work to being very focused on the medical delivery system and medical cost of care, since that seems to be the biggest crisis. No other body is doing that. We've got advisory committees and planning groups for just about anything else we've talked about and haven't spent a lot of time addressing directly -- behavioral health, long-term care.

Whether the community is getting what they need from those groups is another question, and I don't know if it's a question for us to get involved in or not, or maybe it will come through this state health planning process. But there are other bodies created in statute that

exist to -- reading the authorizing language, are responsible for planning for those other sectors. There is no other body responsible for planning and understanding medical care.

So we've limited ourselves where we could go much more broadly under our charge. We've been limiting ourselves in that way. So it does -- it makes me a little nervous to go outside the scope of our charge if we are, in fact, doing that. But if we've set -- if we've identified, as a core strategy, engaging employers, and if there is no other group other than the commission as a state-created body -- whether we're state government or not -- if that's a gap that we're seeing that we think we can support -- again, probably more just in a convening and an advisory and a consulting role.

MR. DAVIS: I see where you are coming from, but I think we are good with this. We're engaging employers. We had our friend from Wisconsin, whose name is escaping me, with our first Commonwealth North joint --

MS. ERICKSON: John Torinus.

MR. DAVIS: John. Thank you. You know, that was employer-focused, as was the last

Commonwealth North one.

This seems to me to be within the context of what we're trying to do, which is sustainable health care, within our achieving the goals, the overall goals of the commission, lowest health care costs and longest life expectancy and all those things. That doesn't happen just through state-funded programs; it happens through the employer sector as well. As Commissioner Streur was saying, it's all these different ways that health care gets financed.

So to have -- with saying that, to have this group that's organized as employers and you're familiar with them -- they're credible, very credible -- say, "Please synthesize the learnings that you've had for us so that we can take advantage of them," that seems completely appropriate.

And to have a conversation with them to see if we're on track is a whole nother thing. Now to just -- not to forget what we talked about this morning and our role, and I understand -- now I get what you were saying about the panel. You know, part of the state planning is to understand the state is spending money here,

here, here, here. What's being done about it? We're not telling them what to do about it, but we have kind of an oversight or advisory role to it.

And the same with the employer side of the equation, and hopefully with the DOD at some point as well to have that kind of -- and the tribal system to have it. So we can't leave out the employer side of it --

MR. MORGAN: Right.

MR. DAVIS: -- and it would be inappropriate for us, because we wouldn't be getting towards our highest overall stated goals.

So I'm personally very comfortable with this product from the commission.

MR. MORGAN: We're just trying to help them. We're not trying to get them to do anything that's --

MR. HIPPLER: "I'm from the state. I'm here to help you."

(Laughter.)

MR. MORGAN: That's right.

MR. DAVIS: "We're not from the state, and we're here to help you."

MR. MORGAN: "I'm from the United States Army. I have this bayonet on my gun to help

you."

But, I mean, all you're saying is, "Here's a bunch of stuff you can try. We're not telling you you have to do it; we're just saying here's some stuff."

MR. DAVIS: "Here's what we've learned, what we think we've learned, in our opinion."

MR. CAMPBELL: I'm fine with steam ahead, and if we get our wrists slapped, then somebody will tell us.

MS. ERICKSON: Just continue?

MR. CAMPBELL: Yup.

MS. ERICKSON: Well, I'm make a few revisions to this, based on your feedback. And if any of you have suggested improvements that's more along the wordsmithing line that you want to e-mail to me, I'd be happy to work on incorporating those.

And I'll keep you posted. I don't know -- I think our next meeting will -- in June, we're working on trying to hold that meeting at the VA Medical Center conference room. And for part of that, our focus for that meeting will be around the learning session on the VA and DOD health care system in Alaska.

So the next meeting might not be the right one, but we do want to start bringing the leadership from that HR leadership network to the table to have a conversation with you all. So I'll keep you posted as this document evolves with feedback from them as well, and I think it will be a work in progress for a while.

Yes, Keith?

MR. CAMPBELL: Will Colonel Harrell be replaced by that time, do you think, on the commission?

MS. ERICKSON: I hope so. I can't speak for the governor's office and the process.

MR. MORGAN: Why don't you look over there?

(Laughter.)

MS. ERICKSON: Emily is in a different office, and we're not going to hold Emily responsible for that part. I think -- I'm hopeful that getting our vacant seats filled will happen quickly once we get past the end of the legislative session. It sucks a lot of time and energy away from everybody.

MR. KELLER: Sorry about that.

MR. MORGAN: Where is Val? Is she

on the phone, or is she sick?
MS. ERICKSON: I think she had a board meeting.
MR. PUCKETT: She's sitting right back there.
MS. ERICKSON: No, we'd heard from Lorena that she has a board meeting --
MR. PUCKETT: Oh, okay.
MS. ERICKSON: -- that she needs to be at right now.
Is that right; Pat?
MS. JACKSON: I know she was going to be on -- she was on the phone this morning, and I know she wasn't going to be able to be at the whole meeting; so I don't know if she's here now.
MR. MORGAN: I was just a little concerned.
MR. CAMPBELL: Next?
MS. ERICKSON: Well, I think -- did we hit everything that was on that previous agenda? We can take a look -- we can have an early break and reconvene at 3:15. Shall we do that? Because we don't have Andrew here. Andrew is not here yet, is he? Okay. Let's take a five-minute break.
2:53 PM

(Off record.)
3:11 PM

2014 STRATEGIES:
FRAUD & ABUSE PREVENTION

CHAIRMAN HURLBURT: So our next session is on Medicaid Fraud and Abuse Prevention. And we've talked about this a little bit before. I think that all of us believe that this whole health care business is so important, and it's a moral issue that there is no room for fraud and abuse.

I think we also believe that the number of bad apples in the barrel is pretty small in terms of the universe of physicians or of hospitals, but that that should not be tolerated. And we all recognize that, even if it's a relatively small number of bad apples, that there is so much money -- $3 trillion to $3.8 trillion in our country a year now for health care -- that a very small percentage of that would run our state forever.

And so we appreciate your coming to help us focus on that, to learn some of the things that we're doing here as a state, to help

educate us. Certainly there is the potential for saving money, where we have this insatiable appetite for more, for doing good things, and we don't want to waste it; but also to what you're doling for this incredibly important industry to make sure that we don't have these bad things going on. So we appreciate it, and I'll turn it over to you all.

MS. ERICKSON: Oh, can I say one more thing, Ward, just to prompt commission members to be thinking. If we have time at the end of the presentations today, we'll do a little bit of brainstorming just to capture some bullets about your initial thoughts about what you felt you learned. And if you have any ideas -- if you think we should be looking at ideas for recommendations to discuss and refine later in the year, then we'll identify those.

And if we don't have time to do it at the end of the day today, we'll be doing that tomorrow morning. But just so you're thinking along those lines and knowing we're going to do that next after our very enlightening presentations we're going to have.

MR. JONES: Thanks. And I do want

to say thanks to Deb for rearranging our schedule and putting us -- possibly the most boring topic you're going to have in the next six months -- on a Friday afternoon after 3:00 on a sunny day in Juneau, Alaska. So thanks for that, and I hope I can keep you guys with us.

I'll try and move quickly so we can get to the better part of the presentation, because Andrew is, by far, the better part of the presentation.

So we are going to go ahead and get started. Acronym soup. Most of you guys are probably pretty familiar with most of these, but let's just run through it quickly. I've been known to use acronyms as if they were real words, so just to be aware.

So ACA: Affordable Care Act.

CMA: Centers for Medicare and Medicaid Services.

MIP, MIG, MIC: Medicaid Integrity Program, which created the Medicaid Integrity Group, which hires Medicaid Integrity Contractors, created by the Deficit Reduction Act of -- what was it? '06 I think.

OIG: The Office of the Inspector

General, Health and Human Services.
MFCU: The Medicaid Fraud Control Unit, that's Andrew's shop. We used to have a program manager in health care services who always, instead of calling him MFCU, he would call him -- (coughing) MFCU, and I couldn't tell if he was coughing or sneezing or actually referring to the group of fraud investigators.
SURS: The Surveillance and Utilization Review Subsystem.
RAC: Recovery Audit Contractor.
PERM: Payment Error Rate Measurement.
CHIP: Children's Health Insurance Program.
REOMB: Recipient Explanation of Medical Benefits.
And ICE: Immigration and Customs Enforcement -- I think. Isn't that what that is? Okay.
MR. PETERSON: And that one changes all the time.
MR. JONES: You never know?
MR. PETERSON: No.
MR. JONES: Okay. So my part of

this quick presentation on a Friday afternoon in Juneau is going to be to hopefully understand medical assistance provider fraud and the difference between waste and abuse; understand the organizational structure we have here in Alaska.

We have sort of a distinct part, Medicaid integrity, the Medicaid Program Integrity Unit, which is different from the larger states and different from the feds, who operate an inspector general model.

So we want to help you understand current fraud and abuse prevention efforts, including prepayment and post-payment controls. I've got a site on that which, by no means, is meant to be exhaustive or, you know, capture all of the controls; but we want to sort of highlight some of the controls we have.

I want to help you understand some of the impacts of the Affordable Care Act on fraud and abuse prevention efforts. When I was putting this slide together, I started with "Understand the impact of the Affordable Care Act," and I said, "Huh-uh. Back space. Understanding some of the impact," because we're never going to go over all of it.

Understand the current status and focus of -- and on this, once again, there are so many audit programs currently in place. Somewhere in your packet there should be a list of audits and reviews that a Medicaid provider in the state of Alaska could be subject to. That's a large -- yeah. There you go. That's a large spreadsheet.

MS. ERICKSON: It's behind Tab 5.

MR. JONES: And so we're going to go over just a couple of those, which we'll hit -- probably, you know, in these four audit programs we'll go over, we'll probably hit 80 percent of the audits that are conducted.

And then where do we go from here, and how do we improve results.

And we'll be certainly interested in folks' comments, too, as far as, you know, when we get to that place. If we can get feedback from the commission, that would be great to hear thoughts on any ideas that you might have as well.

So, fraud versus waste and abuse. I saw in your strategic plan and outline report that somewhere in the neighborhood of 30 percent of all health care dollars are kind of wasted. So when you look at fraud versus waste and abuse, I

mean, the fraud -- and I'm going to let Andrew talk to the fraud piece -- but, you know, the waste and abuse -- I mean, that's probably the biggest area where we have health dollars at risk and that go away.

Within sort of a subset of waste and abuse are what we would call an overpayment that my shop would be interested in going and potentially recovering. But that's only sort of, like I said, a subset of everything that might be considered waste and abuse out there.

So for an act to be considered fraud, we have to get our prosecutor, Andrew Peterson, involved; and he has to prove beyond a reasonable doubt that this fraud existed. And the standard that we have is somewhat different from other states too. We have a -- in our statutes, we have a reckless disregard standard, as opposed to -- what is it? An intent to defraud standard that other states may have?

MR. PETERSON: Yes. And our death statute for the State of Alaska requires an intent as well. So this is a little bit -- it's a little easier standard to prove.

MR. JONES: And for us to uphold an

overpayment finding -- so on the administrative side of things, we would just have to prove that -- prove it by a preponderance of the evidence; so it's just a 51 percent sort of standard.

So the organizational structure in Alaska -- I mentioned we have what's sort of known as a distinct part program. So our Medicaid Program Integrity section is one distinct group of folks who work very closely with -- and I've listed here the three Medicaid divisions. So the Division of Health Care Services, their quality assurance efforts. The Division of Health Care Services also directs and operates that surveillance utilization review function that we'll talk about in a minute.

The Division of Senior and Disability Services -- they also have a QA section. We work very closely with them, and as well as Division of Behavioral Health. So all of the Medicaid divisions -- so those are the primary Medicaid divisions, and they all have quality assurance sections that we work with.

We sort of meet with them monthly as part of an audit committee to discuss audits and reviews. We work with them on the contract audits that come in. We share the information on

preliminary audits before they actually go to a provider. "We're checking with our program folks and, hey, does this look right to you?" So we do have a very close relationship with those guys.

If you were to sort of take this organization chart and think of an inspector general model, you'd sort of, you know, take sort of the department. And then right under the department, you'd have maybe an IG. And then all those QA sections might report up under it. You know, there's various models out there of how we structure it, but this is very typical of a smaller state Medicaid program organizational structure.

So components of a model fraud control strategy. So what does make an effort to prevent fraud, waste, and abuse? What does make it effective? So a commitment to routine and systematic measurements, so having, in our case, sort of audit programs in place that are done consistently, annually, on an annual basis.

Resource allocation for controls based on the seriousness of the problem. So where are you finding issues, and maybe we should focus our effort there. So, I mean, that's pretty straightforward, is that, you know, we've had a lot

of effort recently -- well, ever since -- of course, since Andrew has been here, probably -- in some of the home- and community-based waiver, PCA programs. And that's not surprising, because you do have -- in some of those programs, you're lacking some of the basic controls that you get out of a standard patient-doctor relationship.

So, you know, there is no -- in a lot of these cases, there is no arm's-length transaction when you're getting health care services. And that is a control in and of itself which is lacking in some of those home- and community-based waiver programs just because of the nature of the program.

So a clear designation of responsibility for fraud control. I think we've done a good job of that.

Adoption of a problem-solving approach to fraud control. So this is more than just having Andrew prosecute the bad guys. This is sort of being proactive and looking at: Okay. Well, how did the bad guy get there, and what control was breached so that they could get there? And, okay, let's think about this, and how do we prevent that in the future? And so it's sort of a

standard continuous quality improvement model that you think of when you're talking about this.

Deliberate focus on early detection of new types of fraud. So Andrew goes to a group called NAMFCU -- and we can't make this up -- the National Association of Medicaid Fraud Control Units. I go to a thing called NAMPI. It's the National Association of Medicaid Program Integrity.

It's good to touch base with the other states and see what's happening outside, because it's going to show up. And we've, you know, had cases where you get tipped off on either a provider who is moving from state to state or, you know, a new scheme that might be sort of making its rounds. So those national conferences are extraordinarily helpful.

Fraud-specific prepayment controls. So this is actually part of the Affordable Care Act as well. The Affordable Care Act requires -- let's take a step back. The Affordable Care Act created a thing called a credible allegation of fraud. And in cases of a credible allegation of fraud, the state Medicaid agency must suspend payments to that provider.

So if we do have something that meets the standard of a credible allegation, we must suspend payments to that provider. And this is sort of -- right now, it's a sanction that we can impose and cut off Medicaid payments to a provider.

Obviously, this is something that's not undertaken lightly; so it does create, you know, a large effort on behalf of not only the program integrity folks, but the cognizant division is extremely involved because there is -- you know, first and foremost, we are interested in the welfare of our recipients. So if we are -- if we stop payments to a Medicaid provider, the potential is that they'll stop providing services. And if that happens, we need to be ready to have those folks placed somewhere else to make sure they are still receiving services.

And then the seventh item of a model strategy includes: Every claim faces some risk of review. And you'll see, as we go through the -- I think there are four programs, audit programs, that we're going to talk about that -- not every audit program is designed to look at everything. They are sort of designed to look at

different things, and we'll go over that in just a minute.

So prepayment controls and post-payment controls. So on the prepayment side -- and, once again, this is not intended to be sort of an exhaustive list, but it's sort of what came to me as I was putting this together.

So we have provider certification. And that can be -- actually, the certification shops in the Medicaid divisions both -- and this would apply to licensure as well, so there is licensure and certification. Within the Medicaid divisions -- like Senior and Disability Services, they go out and they certify their providers.

So that's sort of one aspect or one dimension of certification. The other dimension is the concept of precertification for services, which is another control, making sure that, you know, is someone -- really making sure that they need the service, making sure that it's certified ahead of time.

Background check. So the State of Alaska is actually one of the leaders, I think, in the background check area. We are ahead of the game, and we do have -- most of our providers are

subject to background check requirements. So that's a plus, certainly, in the State of Alaska's favor.

Provider enrollment. And this is just going to flow right into the Affordable Care Act. One of the sections of the Affordable Care Act has really increased a lot of attention on provider screening and sort of the enrollment requirements. So this is one of those front-door, you know, controls that really do make a lot of sense. And we'll talk more about all that was enacted with the Affordable Care Act with regard to provider screening in a minute.

Other prepayment controls, so your claims processing system. Obviously that's a big control tool right there. So it's looking for, you know, some of the basic editing. I mean, you know, surgical procedures that can only be done on one of the genders -- you know, if it's showing up on the other gender, then we need to look at this. That type of thing, you know, is easily caught in a prepayment edit-type world.

And then payment suspensions. We talked about that a little bit with the requirement of the Affordable Care Act and payment submissions.

So post-payment controls, the REOMB process, Recipient Explanation of Medical Benefits. So what that process is -- that's actually done by our fiscal agent, managed by Health Care Services. And in that, they will take a sample -- and we are looking at a targeted REOMB process, too, in the future. So that will take a sample of claims, and they'll actually send a notice to the recipient saying, "Hey, you know, we noticed that you were in the emergency room" or "You went to a physician" or, you know, "Did you break your arm on November the 2nd?" And that kind of feedback and information.

You know, it's different in the Medicaid world. You're used to getting an REOMB or an EOMB, you know, typically after every service that you receive from Aetna or from whoever. So in the Medicaid world, those don't go out as an automatic. They're only sort of -- they're targeted. So, you know, that's a piece of the control function. I mean, when I look at those, it's, "Yeah. You know, I did receive that service." You know, I've actually have had a case where I looked at a claim and said, "That is not me." You know, Doug Jones -- there's at least

three of us in the Anchorage/Eagle River area. So I looked at this and said, "No, I've never seen this doctor before." And so I called him up and said, "Hey, you know, what the heck?"

"Oh, yeah. I'm sorry. That was someone else."

"Yeah. Thanks."

So that can be effective in just making sure -- that's just sort of a heads-up check. You know, "Did you get that service?"

And so the post-payment controls that everyone loves is audits. I know the providers love audits and, man, you know, from my perspective, too, the world has changed dramatically in the last three years. You know, ever since the Affordable Care Act came out, I mean, we have initiative after initiative after mandate after mandate; so a lot of work going in there.

Claims data mining. So that, you know, some people -- you know, you can call that an audit. That may be the precursor to an audit, just reviewing data; and we'll talk more about that a little bit later too.

So other controls include

technical assistance, sanctioning providers. You can educate providers. Mr. Peterson is actually one of the strongest post-payment controls out there, probably.

So provider terminations, and then the OIG list of the LEIE, the List of Excluded Individuals and Entities. So if we do have a bad apple out there, a bad provider, and they do get charged or convicted of fraud or something, they will go on a terminated provider list. They will go on a List of Excluded Individuals and Entities, which ultimately will prevent them from getting in the door in another state. So, once again, you have sort of this continuous, circular, you know, hopefully improvement process.

CHAIRMAN HURLBURT: On background checks --

MR. JONES: Sure.

CHAIRMAN HURLBURT: -- is that something that you do separately, or do you rely on the various professional boards?

MR. JONES: So the boards do all the licensing of the professionals, but the state has a background check unit that does any provider that we license or certify; so all the PCA

providers.
CHAIRMAN HURLBURT: For Medicaid-specific?
MR. JONES: Yes, Medicaid-specific.
CHAIRMAN HURLBURT: So that's in addition to what, say, the medical board or the dental board does?
MR. JONES: Exactly.
MR. PUCKETT: Is this a criminal background check, or are they financial background checks?
MR. JONES: Primarily criminal.
MR. PUCKETT: Just criminal?
MR. JONES: Yeah.
MR. PETERSON: And we are actually starting to prosecute certain individuals who have, in the past, needed a variance to work someplace. They move to a new facility. They know they need a variance. They don't apply for one. They're working with medical records, they're working with individuals or billing the state directly, and that's a clear violation of the state regulations. So we are starting to criminally prosecute those cases, because it's a way to get them on a state and federal exclusion list if they're going to just

intentionally violate those regs.

MR. JONES: So the Affordable Care Act. One of the provisions of the Affordable Care Act -- and this is just fascinating stuff -- is Section 6401, the enrollment piece. It requires levels of screening, including initial enrollment site visits, based on levels of risk of fraud, waste, and abuse.

So Medicare has actually already done this. They've taken their provider population and have ranked them as sort of high-, medium-, or low-risk providers. The Medicaid program in Alaska is currently going through that process. And based on how those rankings turn out, there are requirements for -- one of the things is the initial site visit.

So you all may have heard stories of the storefront in Dade County, Florida, that is nothing more than a P.O. box. And they're a DME provider, and they have been billing Medicare for, you know, five years, and $3 million went out the door. And finally someone decided to go show up at the provider location, and there was actually nothing there. So this provider -- you know, this initial screening piece is, I think, designed to

put a stop to that, you know, on that front-door sort of scenario.

So it also requires the imposition of application fees. I think they are $500 for a facility-type provider and $200 for an individual provider.

It requires periodic revalidation of enrollment. So providers in the state of Alaska, until recently, until the new MMIS when we did a giant revalidation effort -- we had never really gone through and revalidated everyone's enrollment.

So this type of activity, you know, will certainly help shake out folks that -- you know, if they're just not billing, you know, they sort of get dropped off. But that revalidation process will sort of bring them back up through the process where we will, again, try and collect information.

And that's another piece of this, too, was ownership and control information, another thing that the Affordable Care Act has been trying to make that states are capturing in their MMIS. A lot of states don't actually have that capability, but we're trying to get that information. That's

part of what they're doing.

A temporary moratorium. So this also provides for the possibility of a temporary moratorium on new provider enrollment by categories of service. I saw that CMS, I think, put a temporary moratorium on DME providers in Florida. Surprise, surprise. So that's another tool in the toolkit that we can use, and that CMS is now using, that came to us from the Affordable Care Act.

It also requires providers to establish a compliance program.

So if we start talking about audits -- and I know this is really hard, talking about audits on a sunny Friday afternoon. But here we go. We'll try and make this as painless as possible.

So the first one on the list is the most popular -- well, let me rephrase that -- is the most well-known audit program to an Alaska Medicaid provider. I think this Alaska statute, AS 47.05.200, was enacted back in 2003, I think, that time frame. So we have been doing annual audits of Medicaid providers through an independent contractor ever since this was enacted.

The scope -- now, these are

Medicaid-provider-focused. So it's per individual Medicaid provider ID by calendar year. And those years -- it's sort of changed over the years, but now it's on a calendar-year basis. And we pick one provider ID and then audit all their claims for that period.

When we do that, we do a -- they'll take a statistically valid random sample of that providers claims for that period. Okay? So we do utilize extrapolation. The way we extrapolate has changed a little bit over time. And I'm not going to delve into that, unless you guys really want to. But the way we extrapolate has changed a little bit. Generally speaking, right now, we use the greater of actuals, or a one-sided 90 percent confidence interval.

The Myers & Stauffert audits, like I said, are provider-focused. And we do have a low-volume cutoff. So there's -- we're not going to select a provider for audit under the Myers & Stauffert program if they billed the Medicaid program less than $30,000. We're just saying, "Nope. Not going to do it." There is too much . . .

So we pay these guys -- we pay

Myers & Stauffert on a per-audit basis. Those audits were about $8,000 apiece. Now they're about $10,000 apiece. So each audit is -- you know, you have to weigh your sort of cost/benefit analysis. If you're going to have a provider who is, you know, a really small provider, we are not going to spend $10,000 auditing them through one of these audits.

CHAIRMAN HURLBURT: So they go in to the provider's office and have the medical records pulled to see if it's consistent with the claim?

MR. JONES: Yes. So the typical scenario is, Myers & Stauffert would do their selection, their sample selection, based on the claims. They'd send that to the provider and say, "Here is the sample. Can you please send us the supporting documentation for this sample of claims?"

So when that comes back, then Myers & Stauffert will do a review of what they submitted. And then, at that point, there is -- we do about 30 percent field work on these audits. So about one in three of these Myers & Stauffert audits, they will actually go, "Okay. Let's go out to the provider's offices, sit down, see if there

is any other information, see if there is anything we're missing in the process," and go through a slightly more detailed review.

CHAIRMAN HURLBURT: So the other two-thirds, you ask for medical records?

MR. JONES: Right. And it's completely what you would call a desk review.

CHAIRMAN HURLBURT: So when you go in to the provider's office, you notify them in advance that you're coming --

MR. JONES: Yes.

CHAIRMAN HURLBURT: -- but not what you're going to look at?

MR. JONES: No. Typically we will -- we have already given them what we're going to look at through a Myers & Stauffert audit.

CHAIRMAN HURLBURT: The patient claims?

MR. JONES: Yup. We already gave them that list of claims. So that went out in advance. Yup. So they already knew what we were going to look at before we showed up at the door.

MR. DAVIS: Doug, just to clarify, so they are paid X dollars per audit --

MR. JONES: Correct.

MR. DAVIS: -- not some cut of the number of violations they find?
MR. JONES: Correct.
MR. DAVIS: Okay. Great.
MR. JONES: But we'll get to that.
MR. MORGAN: That is next on the hit parade.
MR. DAVIS: That's next.
MR. JONES: I'm not sure if it's exactly next.
MS. ERICKSON: It's two past.
MR. JONES: It's two more? Okay. So it's not next, but it's coming. And that was required by the Affordable Care Act, by the way.
So the Medicaid Integrity Program. So earlier you heard me talk about the MIP, the MIG, and the MIC -- so the Medicaid Integrity Program, which was created by the Deficit Reduction Act, created the Medicaid Integrity Group, who hires Medicaid Integrity Contractors. There once was three Medicaid Integrity Contractors. There was the Education MIC, the Review MIC, and then the Audit MIC.
The Review MIC has just sort of gone away. It's lost favor. They weren't getting

very good results, quite frankly, it didn't seem like, out of the Review MIC -- who was trying to find stuff to give to the Audit MIC. So now they've gotten rid of the Review MIC, and now there's really just the Audit MIC and the Education MIC out there.

So these audits are very similar to the Myers & Stauffert that we just talked about in that they pick a provider and they utilize extrapolation. So they will take a random sample of claims and they'll extrapolate the results over the universe.

What's different about these guys, one thing is that they typically will look at a broader period. If they picked a provider to go look at, they'll typically look at them for a period of two to five, which is, you know, just a much broader scope for one provider.

The similarities are, as I said, typically they'll use the same extrapolation technique that we do, or that we know that Myers & Stauffert does. And so we've had five of these audits so far, and they have focused on dental and pharmacy at this point.

Yes?

MR. CAMPBELL: On this extrapolation, if you come up with a number that you should recover, do you do it across the whole, broad three-to-five years extrapolated, or --

MR. JONES: Yes. So -- and actually we've seen one of them. Most of the Medicaid Integrity Program audits to date have been what they call low/no-finding audits. So this is sort of the result of, you know, this whole process that they use, having the Review MIC give them ideas to go audit.

So one of their great ideas was stainless steel crowns in the state of Alaska. And we'd sent then CDC information. A lot of our kids out in the Bush especially need these crowns, and it's not that we are just -- it's not waste, you know. I mean, these were actually medically necessary.

Well, they wanted to test that; and so we actually did two audits of pediatric dentists in Alaska. And we looked at -- they looked at -- you know, primarily looking for stainless steel crowns. Well, guess what? They were pretty much all medically necessary. There was -- and in both of those cases, where one is not

quite released yet -- but one has already been released as a low/no-finding, and the other one we're in discussions as to whether or not we should call it that or get minimal findings back.

CHAIRMAN HURLBURT: So the trip wire is potential excess of a given type of service, rather than a pattern of really high billings for that particular type of provider?

MR. JONES: Not necessarily. I mean, we don't know, really, what -- you know, how the Medicaid Integrity Program -- how they sort of do their selections sometimes. I knew how they did that stainless steel crown one, though. They just said, "Look. This is a problem nationwide. We're coming to Alaska, and we're looking at this." Okay. I did send them CDC information, saying that we didn't really have a high incidence of it; but they came anyway. So they want to know -- what they're looking for is -- you know, it could be a variety of things, really.

MS. ERICKSON: So, Doug, do you administer this program, or does CMS do it directly?

MR. JONES: They are contracted by CMS.

MS. ERICKSON: So HMS is contracted

by CMS --
MR. JONES: That's right.
MS. ERICKSON: -- not through us?
MR. JONES: Not through the State of Alaska. Yup. Very good point.
So that's another big difference with the Medicaid Integrity Program, is that they are directly contracted to CMS. And so we don't know -- you know, we don't know how much they pay for an audit or how they -- you know, what their reimbursement methodology is. All we know is it's a contract directly between HMS federal, doing business as Integreguard up here, and CMS.
MS. ERICKSON: And it sounds like you do -- you have an opportunity to provide some feedback, where you were providing the CDC --
MR. JONES: Yeah. We provide -- so when they're looking at a state's Medicaid program, they have to come --
MS. ERICKSON: And consult with you?
MR. JONES: -- to the Medicaid program to get our policies, make sure that they are -- you know, that they are performing their review in accordance with our regs, really.

So from that perspective, it is very similar to Myers & Stauffert in that they will come up with preliminary audit. And they have got CMS, which is also in the picture; so these things take forever. But -- so they'll go to CMS. They'll come to us. They'll go back to the CMS. They'll go to the provider as a preliminary. Then they go back to CMS, back to us, and then back to the provider. It's a really convoluted process, so it takes some time to get these things out.

But, yeah. That's a very good point, that these are contracted directly with CMS and not the State of Alaska.

MR. PUCKETT: What is the Medicaid retention requirement?

MR. JONES: Seven years.

MR. PUCKETT: Seven years?

MR. JONES: So seven years. Yup.

Okay. We are almost on to one of our favorite audits here. Okay. Finally. So the Recovery Audit Contract. Somebody was asking about contingency fee contracts. Here we are.

The Affordable Care Act rolled out the Recovery Audit program from Medicare to Medicaid, so that was part of -- Medicare had been

doing the RAC, and they were so successful and everybody loved them so much that they went ahead and pushed them on out to the Medicaid program.

So we've had sort of an operational RAC in place for about a year, I guess. And so what they look at is markedly different than like the Myers & Stauffert audit. So these are more claims-based. They're not looking at a provider for a time period and doing a statistically valid sampling with extrapolation.

They're looking -- they're looking for problems. You know, they're looking for the "How did that claim get paid?" kind of stuff, you know. So they'll look at -- I mean, their favorite thing would be to look at -- you know, if you could find an inpatient stay together with an office visit, something that really shouldn't happen -- you know, if you've got claims sitting out there where Joe was in the hospital, and he also went and saw his physician, you know, on the same day, you know, up in Fairbanks or something; and he was a inpatient in Anchorage. You know, that's not going to happen.

So, you know, that's -- they look at scenarios. So they're going to look at services

after death. They're going to look at, you know, this type of thing and hopefully just take data and say, "Look, there's an overpayment: I know this is an overpayment because look at the data," you know. So they're trying to keep it as clean as possible from that perspective.

CHAIRMAN HURLBURT: And this is administered by you and not by CMS?

MR. JONES: Correct. So this is required for the states to hire a Recovery Audit Contractor under the Affordable Care Act. Yup. So we just got our RAC contract operational. It's been about a year that they have actually been --

CHAIRMAN HURLBURT: This is where, if somebody is passing around a Medicaid card, this is where you pick that up?

MR. JONES: Potentially, yes.

And so no extrapolation for these guys, but they are reimbursed on a contingency fee basis. We paid HMS 10 percent; and that, too, is a requirement of the Affordable Care Act. And that is why we couldn't say, "Look, we've got an audit program in place. We already have this Myers & Stauffert program in place."

And so when the feds said, "Well,

yeah, you have an audit program. But you know what? It's required to be contingency-based." So we couldn't use the Myers & Stauffert, trying to say, "Hey, that's our -- that's really our RAC program." It wouldn't -- it didn't fly, because we weren't a contingency-fee-based arrangement.

CHAIRMAN HURLBURT: I don't mean to be jumping ahead, but are you going to share the dollar amounts involved in relation to our $1.6 billion?

MR. JONES: I could certainly talk about it, but I don't have slides prepared for that.

CHAIRMAN HURLBURT: Not exact numbers, but kind of just broad, ballpark-wise. What are the percentages?

MR. JONES: So are you interested in like what the RAC contract has recovered over the past year?

CHAIRMAN HURLBURT: Yeah. Well, maybe also the total, the aggregate of all the efforts of what we're doing here and what CMS does when they come in, and then maybe the subprograms, where the best return is.

MR. JONES: Yeah. I can talk to you about that. I don't have a slide to it, but I

can tell you that -- so our FY13 efforts in the Program Integrity Section, which would include all of these audit efforts, we recovered approximately $5 million. We identified overpayments of approximately $7 million, a little over $7 million. Of that effort, I would say half to two-thirds of that was probably internal Medicaid Program Integrity reviews that we initiated. Then the bulk of the rest was Myers & Stauffert. The RAC contract has recovered approximately $500,000 over the past year. And the Medicaid Integrity Program audits have recovered about $15,000 over the past year.

SURS, so the Surveillance and Utilization Review Subsystem. Some of you may have seen -- or there is another audit out there -- surprise, surprise. So this one is actually initiated, contracted --

CHAIRMAN HURLBURT: So just back to my question, something less than 1 percent on the total Medicaid billing of direct collections. But then what is your sense of knowing that that's out there has an impact on helping people keep honest?

MR. JONES: Yeah. And that is another very good question.

So we talk about that one, and

that's what we sort of term "cost avoidance." And so how you -- there are a lot of different ways to calculate cost avoidance, which we haven't really, you know, generated a cost avoidance number, to be honest with you.

You know, some people will calculate it. If a provider is terminated, for instance, we'll take a look at that terminated provider and say, "Okay. What did you bill us for the last year?" and then use that as a cost-avoidance number.

I know in just the Senior and Disability Services area, we did sort of move down that cost avoidance road.

And what -- I know you were -- were you involved with that, Andrew? It was like $15 million, I think, was the number they came up with --

MR. PETERSON: Yeah.

MR. JONES: -- based on some of the services. And so that would be just the portion related to Senior and Disability Services, which is, what, about a fifth or a sixth of the Medicaid budget? Something like that.

CHAIRMAN HURLBURT: Thank you.

MR. JONES: You bet.
MR. HIPPLER: Mr. Chairman, may we ask a couple of questions before we move forward, or should we wait till the end?
CHAIRMAN HURLBURT: I think the Chairman set the precedent.
(Laughter.)
MR. MORGAN: He's just checking.
MR. HIPPLER: Mr. Jones, before we go too far, you said we recovered -- in 2013, $7 million of overpayments were recovered? Is that what you said?
MR. JONES: No. We recovered about $5 million. We identified about $7 million.
MR. HIPPLER: Okay. And how -- the $7 million came from a total payment of -- how much was actually audited and reviewed?
MR. JONES: I don't have that number.
MR. HIPPLER: Okay. I mean, it seems like a big number.
MR. JONES: You know, one of the -- certainly one of the -- I mean, we focus on, you know, the Myers & Stauffert audits, for instance -- as I said, we have a low-volume cutoff. We don't

audit smaller providers through that program. It's just not cost-effective. So when we do -- yeah. We're going to focus on -- we're going to go where the money is. That's certainly something we consider in the audit planning stage.

MR. MORGAN: When your colleague was testifying before a legislative committee -- and I can't remember the exact number, but you had a large number of claims that you'd like to get to that stage where you would get the money back, but you simply don't have enough people to do it or something, or did I mishear at the hearing what was --

MR. PETERSON: No. I mean, there's -- I guess it's kind of jumping ahead, but, I mean, there's a limited number of investigators that I have, and these type of crimes or investigations are very paper-intensive. They, as Mr. Jones is indicating, require proof beyond a reasonable doubt; so it's not just a preponderance standard based upon a statistical number to say, "You owe us this money."

So we are -- I guess what I'd indicated is, we are investigating as many cases as we can possibly do right now. If I had more

resources, could I investigate and prosecute more? I anticipate that I could. Obviously, that is, you know, a policy decision that falls essentially to you all and, to some extent, to the governor to determine the proper resource allocation.

But, you know, just to kind of give you an idea, maybe over the last ten years, prior to October of 2012, my unit had prosecuted about 35 cases in the ten-year period. We've prosecuted 72 in the last 15 months, and we have -- we've done a number of -- you know, kind of just jumping ahead, one thing that Doug Jones was talking about is the payment suspension based on a credible allocation.

And historically, the way that worked was, because of the length of these investigations -- an investigation would start, and it may take a year or two to complete. And my predecessor would ask that there not be a payment suspension until the investigation was complete.

We've kind of changed that, and as soon as I -- once we've executed a search warrant or we've gone in with law enforcement and seized the records we needed, and essentially the cat's out of the bag, there's no more surprise that we're

investigating, if we can make a determination that there's a credible allegation, we immediately suspend.

And that's had a pretty significant impact, which comes back to, you know, the cost avoidance at a minimum. You look at the time it takes us from the date of the suspension to get charges filed, we've certainly saved a significant amount of money. That's where, during my presentation at the legislature, we estimated, over the last year, just with Senior and Disability Services, it was about $14.7 million in cost avoidance.

We have -- to date we've recovered a little over $300,000 in judgments. I anticipate that, with the ongoing cases we have, we'll probably have about $1.2 million to $1.3 million in criminal judgments within the next -- maybe the next year.

MR. JONES: Surveillance and Utilization Review Subsystem. So these are, once again, more claims-focused reviews that are performed by Xerox under the direction of Health Care Services. You may -- a provider may never know that they had a SURS review performed.

So they will look at -- I mean, they're basically looking at peer statistics. They're looking at providers' billings in comparison to their peer group. So if they have -- if we have a provider that is billing 99215s two standard deviations above the normal, then they may get a review by the Xerox SURS folks.

Only if something really looks out of whack will they actually do a records request and go through that process of truly, you know, doing an audit. But they will do these types of reviews. So they're sort of just applying these, you know, mathematical standards to claims as they come in; and it's just sort of a -- really, once again, similar to the RAC in that they're just focused on the claims, focused on -- this one is a little different because they are, you know, taking into consideration, you know, provider specialties and grouping providers and making sure that they're comparing apples to apples.

So if they do have a dentist, you know, who specializes in kids' crowns, they're going to group all those together; and they're going to look at that. They're not going to look at, you know, just everybody in general.

And hopefully that's about all of them. Darn it. One more.

Okay. So Payment Error Rate Measurement. So the PERM process, just so everyone knows -- so this is truly an audit of the state Medicaid program. It's not really focused on providers and their medical records, although that's a part of it.

So a PERM will measure three different things. They're going to measure the eligibility of the recipient, so how well we determined eligibility. They're going to measure the claims processing of that claim -- I mean, how it came in the door. Was it priced right? Did it hit all the appropriate edits? Did it not hit -- you know, edits that it shouldn't have? And did it pay appropriately?

And then the final leg of that sort of three-tiered test is, then they're going to look at, okay, well, does the provider -- can the provider support this claim? So they'll look at, once again, the provider's documentation, ensuring that, if they billed an office visit, a 99213 code, was it supported?

So this process was required by

the Improper Payments Information Act, and it's performed on every state on a three-year rotating cycle. So we, the state of Alaska, are just now coming up on our third PERM cycle. Year one, we were the best in our cycle, the lowest in our cycle, at like .6 percent Medicaid error rate. The following cycle, we were second-best in our cycle at about a 1.6 percent error rate.

And so we're coming up on our next base year, is -- we're in the next base year. We're in federal fiscal year '14. So October 1st of 2013 through September 30, 2014, is what -- are the claims that are getting measured.

So the PERM folks are, right now, pulling data from quarter one and will be pulling data from quarter two to look at our Medicaid payments. And they'll be going through the PERM process once again.

Because of our extremely good results in the past, how a state gets rewarded is your sample size decreases for the next cycle. So in 2014, our sample size is 336 claims for Medicaid and 380 for the CHIP program. So other states have easily double that number, depending on how their results have been in the past. But this is just

one more audit that's out there that providers are affected by, but this one is actually really focused on the state and not the providers.

MS. ERICKSON: So did we plan this to align with the startup of MMIS?

MR. JONES: We did not plan it that way, no. And we are concerned about how that's going to -- how the initial quarter of the brand-new MMIS is going to be -- yeah.

MS. ERICKSON: Ouch.

MR. JONES: Yes. As I said, we've been very proud of our PERM results. We've had exceptional PERM results, and I don't know that we're going to be able to say that after the next cycle.

CHAIRMAN HURLBURT: Doug, I understand that the billing methodology is different, but does the tribal health system get looked at by both the states and CMS with the same rigor as private providers do?

MR. JONES: Yes, they do. So there is no -- we do not carve them out in either the Myers & Stauffert process; we don't carve them out in any of the results that we do, or the RAC, even though they're looking at 100 percent FMP. They're

part of the process. You bet. In fact, one of our -- we had a large recovery on one a couple years ago. So, yeah.

CHAIRMAN HURLBURT: Thank you.

MR. JONES: You bet. And I think I'm just about done. Okay.

So where to from here? How to improve results? One thing that Andrew and I have spent a lot of time talking about is the importance of enrolling these rendering providers.

So after the State of Alaska enrolled our PCAs, we -- all of a sudden, we got all kinds of interesting data to look at. And we could start doing some very interesting comparisons, like how does a person work 28 hours a day, things of that nature that -- I mean, you sort of -- you know, you take for granted, but unless you have that rendering ID on the claim, we don't see that when it comes in the door. Now we can. And so it's extremely powerful to have that data right there in front of you.

And there's a lot of -- there's still a lot of provider types that we're still blind to that information. So if there's other home- and community-based waiver providers that are

not PCAs, or some of the behavioral health folks that are not enrolled renderers, we still don't -- we are still blind to that at the claim level.

So I mean, you could piece all that together, but it would take an enormous amount of effort to try and figure out who was working for what agency on what day and go through that type of process.

Once we have them enrolled and we're looking at them, and Andrew is looking at them, we're going -- you know, you can pick that data up and say, you know, "This person worked for three different agencies. And on September 2nd, they submitted claims totaling, you know, 32 hours, and that's not possible." So there's still opportunities out there with regard to enrolling rendering providers.

And that just flows right into increased attention on data analytics and focusing on multiple data sources. So the same sort of thing we're talking about with renderers -- I mean, if we look at additional payers, you may have some of the same issues drop out of that.

So working with Medicare, I know that there is a Medi-Medi Program in place where

we're trying to get access to Medicare data and share information between Medicare and Medicaid. I mean, it's surprising that, in 2014, that that's not happening already as a matter of course. Well, it's not. And so that's something that, you know, is another opportunity for moving forward.

Obviously with -- you know, once you take it one step further with Medicare, is there opportunities with private insurers? You guys had some information here -- you were talking about all-payer databases. So -- and then continue to collaborate. And this I can't emphasize enough, is the collaboration and building partnerships between -- with our partners, our state, federal, and private partners.

CHAIRMAN HURLBURT: Is that happening within the state?

MR. JONES: Yes.

CHAIRMAN HURLBURT: Like if you all pick up a bad apple, does Jim know in DRB, or does Mike know in workers' comp?

MR. JONES: I think there is room for improvement there. You know, we try and -- so far, we've been sort of trying to tear down walls sort of between divisions. And so the next step

would be between departments; right? So, I mean, we're still -- you know, I think we've made great strides within the Department of Health and Social Services, but I think there's additional opportunities that could be out there. Absolutely.

MR. PETERSON: We're starting to do information sharing with workers' comp right now and with wage and hour, for example, the Department of Labor. We now have access to their records ourselves, which is huge, because we can take a look at a provider and go, "Something seems wrong here." We take another look and go, "How much are they making?"

As my investigators say, when a home health care attendant makes half as much, per hour, as my investigator does, but they're making two and three times her annual salary, something is wrong. And so we can usually take one look at wage and hour records and go, "There has to be fraud here," just based on the total amount reported.

But as Doug was saying, you know, individuals will work for so many different agencies, in an enrolled and in an unenrolled capacity, that, absent, this information sharing, we wouldn't know it. And so that's been helpful.

We've been working with the Department of Corrections, sharing information with them. Who else? I mean, a lot of -- yeah. I mean, it's a very -- immigration. I can get into that a little more later, but it is absolutely shocking the amount of help that they have given us. It's been phenomenal.

MR. JONES: Yup. And that's about all I have, I think. Yes. And now I'll turn it over to Andrew.

CHAIRMAN HURLBURT: Any other questions? There may be some at the end.

MR. JONES: Sure. You bet. We'll let Andrew cover his program. Watch the water.

MR. PETERSON: Watch the water. Yeah. So Doug is giving me a little bit of a hard time. When I was testifying before the legislature, I reached for the mike, and my water glass went flying, so -- on TV, nonetheless. And so I suggested that I was doing my part to make everybody else in the room look better.

You know, just real briefly, a little bit about me so you understand where I'm coming from. I am a ten-year prosecutor. My background, almost exclusively, is I'm a

white-collar crimes prosecutor. I'm not your typical prosecutor who does sex and homicide cases.

And probably more importantly, I spent a lot of my time working directly for the wildlife troopers. And anybody who has ever interacted with the wildlife troopers, you know that they are very -- to say the least, they're very passionate about the work that they do.

But I think that really transcended well into this job, partly because, in order to be successful in that job, I had to coordinate with a lot of different state and federal agencies. We were doing some very interesting work. Unfortunately, Doug can't offer me plane rides and boat rides, so I'm not -- some days I wonder why I made the switch, but I'll tell you this, that I was offered this position, came into it with preconceived notions that I've been completely disavowed of.

I mean, Doug Jones, Director Duane Mayes, and everybody that works for him in his shop, they are as passionate and as aggressive as just about any wildlife trooper I've ever met. It has really been impressive to see how dedicated and passionate they are about what they're doing. My

cell phone rings a lot late at night where they're asking about stuff. And it's really -- you know, that's been very comforting.

The other thing I would say is, at least from my point of view, it's quite shocking the amount of fraud we found. I will tell you that the direction we've taken initially has been, in large part, driven by Doug Jones and his folks saying, "This is an area that hasn't been looked at. We're sick of seeing these issues. We need them addressed," and that's where we go.

And we are utilizing just about any resource that we can. We are working with confidential informants, we're doing Glass warrants that are authorized by the court. We are working with state and federal investigators. We're executing search warrants. We're doing anything we can, including sending individuals in to facilities to receive Medicaid services when we think that the facility is providing fraudulent services.

So we are utilizing any resource we can within our limited means, and it's mostly coming through cooperation with different agencies. Everybody has -- whether it's a state or federal agency, everybody has, surprisingly, a number of

investigators or people at their disposal. And so we're spending a lot of time cooperating with those agencies to try and make cases. And I think, over the last 15 months, we've had a lot of really good results.

So it's been an interesting 15 months doing this. I have absolutely zero experience in the healthcare industry, so when it comes to trying to figure out the rules and regulations and what the real intent was, I rely heavily upon the folks in the Department of Health; and they have been fantastic.

So I'll kind of go through a little bit about what we've been doing, what we're trying to do, and I'll do the best I can to answer the questions that you all have.

So just briefly, Medicaid Fraud Control Units, or MFCUs -- most of the states have Medicaid Fraud Control Units. It's required by Congress. I know that North Dakota does not. They have gotten an exemption to operate on their own. But even the District of Columbia does.

In the federal financial participation for the Medicaid Fraud Control Unit, it starts off at 90 percent the first three years;

after that, it's a 75/25 match. So the -- it's an interesting way to look at it. The state puts 25 percent up front for any of the costs of my unit, but the recovery or the savings, every time we get a recovery, whether it be in a restitution order or prevention of fraud, we're saving 50 percent on the dollar. So there is a cost savings there that's, I think, actually very realistic.

Because the feds are providing us with 75 percent of the funds, there's always strings attached to those funds; and so we are limited with respect to what we do. I can't go and prosecute a Medicare case. I can't go and prosecute a fraud case that has nothing to do with Medicaid. So I am limited to what I can provide. If I prosecute -- even though I technically, under state law, have statewide jurisdiction to prosecute any crime, if I do so or my investigators work in non-Medicaid-related areas, the state can be held -- we get audited occasionally, and we would have to -- or the Attorney General would have to write a check for the time we spent doing work that wasn't within our grant. So we try to focus our efforts on medical assistance fraud, allegations of

neglect or abuse, and financial exploitation of patients' assets within like assisted living home-type facilities.

So, as I indicated our limitations, we don't do non-Medicaid cases. We also are prohibited right now from data mining. So what that means is -- you know, Doug has talked to you a lot about the stuff they do with respect to trying to find fraud, doing these audits. They can do their own data mining. We don't. But once the door is open for us, and that can be -- for us it's a credible allegation.

It looks like this thing is going on its own.

MR. JONES: You just started the slide show somehow. One more. There we go.

MR. PETERSON: So what that really means is, we get a credible allegation into our office. It can be a citizen informant calling up and saying, "Hey, we think this person is committing fraud for the following reasons." It can be Doug calling us and saying, "Hey, we've taken a look at these numbers; and this provider, within their peer group, is an outlier." Once we get something like that, a referral, now our gates are open, and we can

start investigating. And do so initially quietly to try and see if we can find something that is nefarious.

This is the current structure. Doug talked to you about the Department of Health and Social Services, so I won't really focus on that. What I think is important about our structure is, my unit falls within the Office of Special Prosecutions. And what that really means is, the Office of Special Prosecutions has 13 specialty prosecutors. They focus on PFD fraud, failure to pay child support. We have a specialty sex assault prosecutor. We have a number of general prosecutors. We have a Department of Public Assistance prosecutor. And so we have a number of other individuals with varying areas of expertise.

If I get a referral of a case that doesn't fit squarely within my jurisdiction, it doesn't just go by the wayside. I take it up to my supervisor. We find a prosecutor to take it and somebody to investigate it. So we're not letting these cases slide by just because it doesn't fall within my mandate.

And that's just kind of how we are

currently structured. You know, as I mentioned before, we have dramatically increased the number of prosecutions. One of the reasons for that is, thanks to the legislature and the governor, our funding was recently increased. We had previously three staff investigators and an auditor. The legislature doubled that, gave us six positions.

And when we went through and did our hiring, we were really fortunate. We hired a retiring DEA agent. We hired a gentleman from Idaho who had 30 years of law enforcement experience doing homicides and bank robberies. And he wanted a new life and came up.

And so we have three of my six investigators currently are former law enforcement officers who have a great amount of experience. And then we stole a couple of investigators from occupational licensing that had significant experience in the area we need.

So we have really been fortunate. We have acquired some very talented individuals who are really passionate about what they're doing, which always helps.

With respect to the funding, our funding is about -- this year, it's $1.5 million.

And if you look kind of at the bottom line, 2010, the total funding, $849,000. We got four prosecutions. In '11 we had one. In '12, we had one prosecution. In 2013, we had 19. And these are actually convictions. And so far, in 2014, we have secured 27 convictions. We have a number of cases still pending and a number of ongoing investigations, so I anticipate that this number is going to continue along. At some point, it's going to cap out. We can't keep -- with the number of investigators we have, we can't keep escalating that number; but I anticipate that it's going to continue along at this rate for a while.

I know you've all asked this number, and I've been asked this repeatedly, is: What is the amount of fraud in Medicaid? You know, that's a number I can't answer. I've relied upon FBI financial statistics. They say it's between 3 to 10 percent, you know; and I think that number is going to vary depending upon the industry. When we're talking about physicians or individuals who have got a significant amount of education and a lifetime of work getting to the position they're in, there is a serious risk in committing fraud. A conviction for medical assistance fraud results in

a lifetime ban from providing Medicaid services. It also may be the impetus for a ban from simply practicing the profession they spent a lifetime to be able to operate in.

That said, when it comes to certain areas within the home health care industry, waiver services, transportation services, the kind of services where any one of us in this room could go out and start providing those services tomorrow, there is not the same skin in the game when it comes to committing fraud.

We have one ongoing case that Doug and I have been working on for a long time with respect to a personal care attendant agency. We have charged approximately 40 individuals within that agency for committing fraud. We've got over 30 convictions at this point. That is over 10 percent of the employees of that company have been charged or convicted of committing fraud.

And the hard part, when it comes to a home health care-type setting, as Doug mentioned earlier, is the services are being provided oftentimes by family members. They are being provided in the individual's home.

It is extremely difficult to find

the fraud, because it's happening outside of an area where we can easily, you know, ascertain what's going on and what services are being provided. And when it's a family member saying, "I'm providing services of daily living to my parent," how do you prove that that is fraudulent, absent certain circumstances?

The way we have been able to prove these cases is relying upon assistance from the Department of Health. They've been instrumental. The Department of Labor helps us look at earning statistics. Immigration helps us by showing us international travel history. Oftentimes what we find is somebody has been overseas for a month and yet they have been billing Medicaid for the entire time that they've been gone. That's a very common scheme that we see.

And we are actually -- you know, then we try to identify domestic travel records, anything like that that we can utilize to show somebody isn't where they say they are.

CHAIRMAN HURLBURT: Andrew, if the 3 to 10 percent is a credible estimate from CMS, I guess, and if my back-of-the-napkin calculation is right, that we're recovering about 1 percent of our

$1.6 billion, that means there is the potential of 3 to 10 times what our current recovery is.

MR. PETERSON: Yeah. I don't disagree with that. I mean, it's --

CHAIRMAN HURLBURT: So $50 million to $150 million of fraud out there in Alaska, based on CMS estimates of their experience nationwide.

MR. PETERSON: Yes. And I would -- I mean, I guess, when you're looking at these numbers, and we look at -- we're paying $1.5 billion a year for Medicaid services. There are a total of eight individuals in my shop and six in Doug's --

MR. JONES: Seven.

MR. PETERSON: -- seven looking at this. I mean, it is a significant amount of money that's out there on the table. And I guess the question really is, you know: What's the return on investment from having more or less investigators looking at it?

So I kind of touched on this a little bit, but getting to where we are right now, one of the things -- you know, Doug mentioned it, which is the cooperation between the agencies. Doug and I went to a conference, one of the first

ones I went with him on -- the only one, actually, I guess. We went where program integrity directors and Medicaid Fraud Control Unit directors all got together, and they talked about cooperation. And I found this to be quite silly, to be perfectly honest, that professionals had to get together and talk about: How do we cooperate?

What I found out was that, in most states, the Medicaid Fraud Control Unit director and the director for program integrity don't talk. They don't work together. They don't share information. They really don't get along, which is absolutely surprising, because they all have a job to do. It turns out that a lot of it happens to be political differences in states where you have an attorney general that may be one party and a governor that falls under another. But that still seems silly when they have a job to do, which is to prevent fraud.

So while we were there, we got the idea from Texas to start doing what is called a sweep, just going in, picking an area where we know there is a lot of fraud, finding someone we're going to investigate, and doing it. And that's really what started a lot of the prosecutions that

we're doing.

We came back. We received information about this specific home health care provider that was doing stuff that seemed really inappropriate. And we got together with program integrity, investigators through quality assurance in the Department of Health, the FBI, Homeland Security, the Office of Inspector General agents. And we all kind of got together in a room like this, and we said, "How are we going to figure out where the fraud is here?" You know, "How do we attack this?" And that's resulted in a lot of these prosecutions.

So coordination between divisions within the Department of Health or other folks has been instrumental in increasing the number of prosecutions that we are doing.

These are just a few of the other folks that we work with on a regular basis. I point out the Department of Corrections. That's one of my favorites, because we've been able to access Department of Corrections databases, check it against Medicaid billing, and, guess what? I don't know how you're getting Medicaid services when you're in jail, but it happens. So that's a

fun one for me.

MR. MORGAN: Can I ask a question?

MR. PETERSON: Sure.

MR. MORGAN: I know we had the U.S. Attorney in a national HFMA meeting. They have one guy that -- his office does all their fraud stuff, mainly for Medicare. But he said they had like a ring in New York that got $60 million or $70 million for billing over two or three years for 12 or 13 dead physicians. There were no patients, and the docs were dead. They just got identity theft.

Have you run up against where someone actually billed for a provider who actually had passed away in this state? Or is that --

MR. PETERSON: I haven't seen where a provider has passed away. I have seen where a recipient has passed away, and there's still billing happening. And we've run into situations where individuals will take another recipient's identification, using it to get prescription medication.

So, I mean, I think that you hear some pretty significant horror stories from the Lower 48 that I think we are going to be fortunate

to not have here, primarily just because -- I mean, while I think $1.5 billion is an astronomical amount of money, I think it's miniscule compared to what the City of Miami spends in a year.

MR. JONES: It's the pharmacy line in Florida.

MR. PETERSON: Right. I mean, I don't know if this number is right, but I think I heard Miami is like $30 billion a year or something. So when it comes to figuring out -- I mean, Alaska is a pretty small player in the overall scheme.

But to go back to kind of what you're saying, going to these national conferences, meeting with other directors, and I'm learning about fraud schemes that are happening. We do see them up here, and some of these fraud schemes -- there are places where they actually provide classes to individuals that are interested in getting into the Medicaid billing system.

And they say, "Here," you know, "Here's a weakness that you can exploit."

And so one of the things we try to do is, when we identify these weaknesses, work with Doug's shop, work with the commissioner, and try to get new regs passed that will tighten up, you know,

weaknesses that we find.

So we've kind of just -- we've talked, really, about this already. I mentioned this previously, but we've had 75 suspensions based on credible allegations of fraud. Most of those have been prosecuted or charged at this point, but there are a number that haven't.

We have one case that's with the U.S. Attorney's office. It's a transportation company. The company came into business billing nothing, you know, a few thousand dollars the first month. Within six months, they were billing about $150,000 a month. And we were able to determine that they were billing for rides that weren't ever happening.

And so once we had a credible allegation, we executed a search warrant with the U.S. Attorney's office; and we suspended them. And now that case is pending with the U.S. Attorney for prosecution. And one of the individuals has actually been charged but has chosen to leave the country. Probably a good idea.

As I indicated, we had a PCA agency. That agency -- again, this is like an interesting trend that we watched. The agency was

billing about $1.2 million a year back in '08 or '09, maybe. And then, each year, it was increasing to the point where, in 2013, it was on track to bill $12 million for one year for simply home health care attendant services. And we were able to ascertain a credible allegation of fraud in that case, and the agency was suspended.

That's where we were actually going to be today, was in a hearing to determine whether or not they were going to -- their suspension was going to be -- continue to be imposed. And they withdrew their appeal of our suspension, so that was actually a good result.

MR. PUCKETT: And I just assume that "PCA" is "Personal Care Attendant"?

MR. PETERSON: It is. I apologize. Sir?

MR. CAMPBELL: I haven't noticed a lot of publicity about this sort of thing. Is there a deterrence in publicizing this sort of thing?

MR. PETERSON: Well, and I smile because, you know, prosecuting Fish and Wildlife cases for the state, I charge somebody with illegally bear baiting, and it makes the front page of the ADN. I mean, it just does. It's a reality.

You walk into Anchorage court, Anchorage Superior Court on any given day, and you will see somebody being sentenced for sexual assault, and that may not even be anybody from the press there.

I mean, so it's -- you know, it's a -- I don't know. It's a sad reality, maybe, that when it comes to health care fraud, there is not a lot of publicity. So one of the things that we did to increase this publicity is, back in July of last year, we charged 29 individuals on the same day, and we had a press conference. And that garnered some publicity.

And then that has gotten some of the Anchorage press, at least, interested in what's going on. I had a sentencing in superior court yesterday of a woman who stole $86,000, and the press was there to cover that. And that was in the Alaska Dispatch today.

So we are doing what we can to kind of get some interest out there, but certainly the reality of it is that Medicaid fraud is not the most -- it is not the most interesting topic to everybody in the state of Alaska, but we're trying to do what we can to get the information out there.

I would say that, you know, for

those of you that are involved in legislation -- I mean, one of the things that we talk about when it comes to prosecution is -- it's called the Chaney criteria. There are certain factors that the court takes into consideration in determining an appropriate sentence. And one of those factors is general deterrence. And I would make the argument to you that generally deterring somebody who is going to be involved in gang activities or in homicide or sexual assault is probably -- that's probably the last thing going through their mind when they're getting ready to commit this offense; right?

But the reality is, I fundamentally believe that when it comes to prosecuting big game guides or when it comes to prosecuting Medicare or Medicaid providers, that's something that they think about. I mean, the reality is, there is a finite number of people providing these services, and they know when somebody within their industry gets prosecuted or charged or even audited. I mean, that's something that everybody talks about. They know. And when the outcome has negative consequences, people see that. They realize it. And I fundamentally think

they're going to think about that the next time around.

In my sentencing yesterday, you know, I had to agree with the judge, I mean, the lady that I was sentencing was in her early 50s. She'd never had a criminal charge. She was not a typical person you see in court, somebody who is in court all the time, crime after crime; and the only real option is to throw them in jail.

That wasn't this lady. She had, however, started off -- in I think '09, she billed like $220 in overlapping billing. Didn't get caught. And that increased to the point where, in 2012, she billed $26,000 for services she hadn't provided with respect to home health care services.

You know, and I argued that she needed to have some active jail time. She's not a danger to the community, and the reality is that somebody like her is going to be put on ankle monitoring; but the court disagreed. The judge made a very good reasoning for why; but, I mean, the reality is, she's barred, lifetime, from being in this industry. So that's the consequence. And the judge wanted to see her back out in the community on a form of probation and working to try

and pay back the State of Alaska the money she owes.

So, I mean, those are just realities that we face when it comes to these type of cases. We're not always going to get jail. We're not always going to get the sentences we want. But the reality is, that's probably not the biggest risk for some of these individuals; the biggest risk is the loss of a career.

And then just as Doug and I previously talked about, the estimated savings, $15 million, that's based upon just saying, "These are individuals we suspended. This is what we would have been paying, absent the suspension."

The reality is, for some of these, the recipients of services are going to go to other agencies; and we're going to be providing those services elsewhere. But the factor that's really, really hard to measure is the deterrent effect. One of the things that my investigators are running into all the time now when they contact home health care attendants and are interviewing them about travel, they're acknowledging that the word in Anchorage is, "Don't bill while you're traveling anymore, because they're checking."

That's a good result. I mean, so every time somebody goes on a trip, we're saving that money. Or maybe they're getting somebody else to legitimately provide the services for their recipient while they're gone, and that's a fair result too. I mean, that's what we want.

So just some of the prosecutions we have done -- we've talked a lot about the personal care attendants. You know, I can't dispute -- I mean, some folks say that's low-hanging fruit. That's true. There has been very little prosecution in this area in recent years, and we were spending $150 million a year on these type of services; and it's one of the fastest growing areas within Medicaid. I think it's an important area. It needs to be prosecuted, and there needs to be some deterrent effect on it.

We prosecute theft cases. If somebody walks out of Fred Meyer or Walmart with a $50 pair of shoes, why wouldn't we prosecute tens of thousands of dollars when they're stealing it from the state and federal government? And so we're focusing on that.

The number of cases against assisted living home employees for abuse or assault

of recipients, failure to report incidents of harm, endangering the welfare of a vulnerable adult -- we prosecute those cases. And we have an interesting case going on against a doctor and an office manager for, again, believe it or not, billing for services not provided while traveling internationally.

And Doug mentioned this previously, but the explanation of benefits. To my knowledge, there are no explanations of benefits that go out to Medicaid recipients, and it makes it very easy for a physician to bill. In this case, the explanation were heard was, "Well, I'm not reimbursed for so much of the work that I do, when I see the patient eight times, I bill for ten to compensate for the money I'm not getting."

No explanation of benefits is going to the individual recipient, so they don't see it. They're not going to report. And, over the course of years, how are they going to remember which dates they went in and which dates they didn't?

So that's been an interesting case. You know, I can only talk about stuff that's public. Portions of this case are public now

because, when we executed the search warrant at both the doctor's house and his office, as well as the office manager's house, we found quite a -- you know, not an extensive amount, but a lot of marijuana and other drugs, which has resulted in criminal charges. And those cases are pending against both the physician and his office manager at this point.

So, you know, it's an interesting case. Is it -- do we see many of those? No. I mean, you can see by my numbers that we're seeing more cases than other areas, but there is some fraud in other areas other than personal care attendants.

MR. JONES: So on those explanation of Medicaid medical benefits, we do send them out. It's on a sample basis, so, as I said, not everyone gets one for every service. It's just a very sort of a sampling of recipients that receive those.

MR. PETERSON: I kind of passed up one slide. It was just the amount of money we think we are recovering. I can back up here real quick. So about $320,000 right now in criminal judgments. As I indicated, we have pending cases. It could be $1.3 million to $3 million, depending on how

successful we are with the pending criminal cases that we have. Again, I have to prove those cases beyond a reasonable doubt and then either have the defendant stipulate to the amount that's owed or prove it up in court. So that's -- I mean, that's always a factor.

And just a couple of notable cases. State vs. Batac was an interesting case. She was a municipal property tax assessor. I'm thankful she's not still working for the municipality, because I'm certain my property taxes would go up, and I would probably be moving.

But she was billing Medicaid for providing personal care attendant services while she was working at the municipality and while she was working at another job. She was working at Home Depot. The municipality and Home Depot both cooperated with us, providing us with her time sheets. It was physically impossible for her to be in all of the places at the same time she said she was.

She received a class B felony, one year in jail. It was on an ankle monitor, so she is out in the community; and restitution and a ten-year formal probation sentence. So that's a

good outcome. And, again, a lifetime ban from billing Medicaid.

The next one, State V. Gunes, this was investigated by the Office of Inspector General agents and the FBI. And then one of my -- my retired Boise detective picked that case up and ran with it. And I will say we've gotten more mileage out of a $100 fraud case than I think anybody has ever seen.

So the Office of Inspector General put a lot of effort into this case. They wanted to see it prosecuted. And what essentially is happening is, when it comes to Medicaid vouchers for transportation, people come into town and they have a voucher that they can simply provide to the cab driver. And the cab driver is supposed to say, "Okay. I took you from point A to point B," which is a legitimate drive.

What this driver -- we thought initially that maybe the agency was fraudulently billing Medicaid. It turned out the agency was being as honest as could be. They were telling the drivers, "If you submit a bill that's reimbursable, we're not paying it." So what the drivers were doing, or this driver in particular, was changing

the destination and locations and then submitting it. Again, there is no -- the recipient doesn't get an explanation of benefits saying, "You went from these two locations," so they don't know. And the driver would then use the voucher. It's on a carbon copy. They would tear it up and use it as four.

So this driver took an OIG agent on one ride, submitted it for four, to places they didn't go. Not the crime of the century, but the results certainly were -- convicted of medical assistance fraud, a lifetime ban, $500 fine, restitution. No big deal, realistically, but the municipality seized his chauffeur's license. They revoked his permit, and they auctioned it off. So that had a pretty good deterrent effect, I think, within the transportation community in Anchorage, that it may not be worth it to fraudulently bill Medicaid $100 for services you don't provide.

This has also resulted in the Municipality of Anchorage changing a lot of their chauffeur permits and rules with respect to individuals who can provide Medicaid services.

We've had another case here, which is a transportation company. They were

fraudulently billing for escort services. In particular, this came to our attention because we had a blind individual who -- you know, he may be blind, but he certainly knows what services he's receiving. And when they asked to reallocate his 160 companion rides, a new -- another 160 authorizations for companion rides, he was a little perplexed when he'd only used that service twice.

So he came to us and said, "I know I'm not receiving this service." And so this company got suspended. And the municipality went through and changed the prohibition on these companies accepting vouchers. It's just an easy way to do it.

And then we've talked about the personal care attendant cases. Those cases are ongoing. And realistically -- again, I would say that all the cases we're prosecuting -- you know, you'd asked about -- the general question was about cooperation with other agencies. And we really are cooperating with all the state and federal agencies we can to, I guess, get the biggest bang for our buck. We have a limited budget, limited resources, and we're utilizing other individuals within state and federal agencies where we can to get the best

result we can.

So I think it comes down to lessons learned, and it comes back to cooperation. From at least the conferences I've been at, the states that aren't prosecuting cases or are prosecuting a minimal number, it's because they don't -- they spend all their time in disagreements with the other agencies, as opposed to cooperation.

Doug and I have a great working relationship. We talk almost on a daily basis, certainly multiple times a week. And we share information as much as possible to the extent we can, and we're doing what we can to -- I guess to save the state what money we can from fraudulent activities.

I'd certainly be happy to answer any questions to the extent I can.

MR. MORGAN: So basically for every dollar that your budget is, you're getting a return -- you're getting at least $5 of cash back, give or take a little?

MR. PETERSON: Yeah. One of my investigators actually calculated that for me. And I don't -- I guess I didn't put that in here. It's between $5 to $8, is the return on investment. And

the state -- so $5 to $8 return on investment, but the state only pays 25 cents on the dollar for our budget.

CHAIRMAN HURLBURT: Your recoveries -- so two-thirds would go back to the feds?

MR. PETERSON: No. No. So our recoveries -- 50 percent goes to the feds, 50 percent to the state.

CHAIRMAN HURLBURT: What if it's from the tribal health system?

MR. PETERSON: That would all go back to the feds.

CHAIRMAN HURLBURT: Because our basic federal match is 50-50; but for various programs, it's more than that. So, on the average, we get about two-thirds, 60 percent, 65 percent federal dollars?

MR. JONES: Yes. If you do a blended rate, yeah. It's something like that.

MR. PETERSON: And, you know, one thing I would say is, I would like to think that everybody is going to pay 100 percent of the money they owe. That's probably not a reality. There are certainly individuals -- I just prosecuted a lady

last week, sentenced her. And I gave her a very favorable deal, because when we contacted her, she had already paid $7,000 of the $8,000 back that she'd stolen before we even knew about her.

So I thought that was a pretty good result. I mean, word was definitely out there, and I thought that showed that she -- I mean, she still got a conviction, and she's still permanently barred; but we are getting some of the money back. I think that the largest savings that we're going to see is the amount that you can't measure, which is the deterrence from fraud, you know, based upon the prosecution. You're just not going to be able to measure that in actual dollars.

MR. JONES: And I think that's sort of a common issue: How do you measure the effectiveness of any fraud program? And you can look at convictions. You can look at dollar recoveries, but sort of that overall effectiveness is very tough to quantify. It really is.

MR. COGHILL: Both of you, thank you, thank you, thank you. Two questions arise, one for -- it's Doug; right?

MR. JONES: Yes.

MR. COGHILL: You know, the various

different audits that come down, they must have some overlap; but at least they have -- at least four of them that I could see look like they end up on the shoulders of some provider somewhere. So is there any quantifiable cost that just starts falling down on them? Because they may think the government is punishing them, too, by making them have to bear the brunt of this. So how does that look from your perspective?

MR. JONES: Yeah, and that's -- I mean, that's something we do hear a fair amount, and that's something I try and coordinate. And so after the Affordable Care Act -- it has sort of brought to us a couple of different audit programs. And we do -- we are very -- you know, we try to be very careful as far as, okay, you know, there is an audit here. In fact, the Affordable Care Act prohibits a Recovery Audit Contract on something that has already been audited.

So the Recovery Audit Contract has a three-year look-back, so they're in front of the game. So there is no prohibition and, in my view -- providers might see this differently -- but my view is that it would be good to have a Recovery Audit contractor come in and look at your claims

ahead of time with no extrapolation, no, you know, sort of -- no big penalties. If they find a claim, fix it. And then, later on, there is a possibility that a Myers & Stauffert-type audit might come on the back end, where there is the random sampling and then the extrapolation.

But, you know, if you're looking at it in the best possible light, well, then, you've already fixed some of your issues here, and so there is going to be less that would be picked up by the extrapolation auditor in the back.

But it's a very good question. And, yeah, we do -- we're very careful in trying to make sure that we don't just beat up providers, from an audit perspective.

MR. COGHILL: Speaking of providers, some of the biggest providers are our hospitals in Alaska. And so ER is one place where Medicaid really plays a big role, but it plays a role in other places as well.

And so because of the auditing, because of the bookkeeping requirements, because of certification issues, are they just naturally better? Is the billing practice clean enough? Do we see any places where -- that you have this cloud

you can't look into? What are some of the issues with the hospitals?

MR. PETERSON: Well, I mean, from my point of view, you know, I'll see these audits of a hospital, and I'll say, "Okay. They failed to document the following services." And then we do an extrapolation, and the hospital owes us $60,000. That is by no means a fraudulent act, for my purposes. I couldn't, nor would I, even consider taking a case like that.

I do think that hospitals and larger facilities are better at their recordkeeping and their management. I mean, there's just -- there's better oversight. They have the computer databases to -- you know, the system's in place to track all their costs and to track the services they provide.

For my part, what happens is, there's been a couple of cases where an auditor goes in, and they go, "Whoa." It's not just wrong; something is really wrong, like we're getting conflicting documents. Now we get involved, and we go in to see. And what we're finding, from time to time, is when a provider gets notice of an audit, they go through and they have a chart party, it's

called. You know, they try to correct everything to justify their billing; and, unfortunately, they're not always very good at it, and so they fail to get rid of the old documents. So that's the kind of case where I would get involved.

But, you know, it's -- the audits have produced a couple of cases that we'll prosecute, but generally it's really an overpayment. And we do -- we approach this stuff very cautiously. I mean, if we get a -- even in some cases where there is a technical violation, if there is a way that we can work with the provider, if it's an honest mistake, to correct it without a criminal prosecution, we do that.

MR. COGHILL: So these hospitals -- they are so complex, because they are really businesses within businesses. And I think an administrator probably has their hands full just trying to keep track of the businesses under their roof; right?

MR. JONES: Yeah. And they also, you know, are typically very good about being leaders in health care compliance. I mean, they'll have a health care compliance shop that is responsible for coordinating -- I mean, Providence

has -- you know, one position does nothing but coordinate all the audits that they're getting.

And what you're seeing here from our perspective -- this is just Medicaid, folks. I mean, there's Medicare. There's -- so for almost every Medicare audit out there -- or Medicaid, there is a corresponding Medicare one. So the RAC started with Medicare.

You know, and so, from the hospital perspective, they are absolutely -- you know, they have to be on top of their game with regard to billing.

You know, I think another piece with regard to hospitals is our payment methodology. So in the state of Alaska, we utilize an inpatient per diem rate, which is very hard to -- there is not much you can do with it. I mean, they submit their cost. The state calculates a rate per day. And so there is -- you know, we have very little findings in the way of overpayments when we typically do an audit of a per diem-paid facility.

Now, that's different when you go to DRGs. If you look at the Diagnostic Related Groups that Medicare pays, there is a lot of

gamesmanship that can happen in DRGs. And so, in those states, or in Medicare, you'll see additional findings. We do have some out-of-state hospitals that utilize DRGs and will pay whatever that state's, you know, methodology is. So we will see some issues with DRGs, you know, out of state. But typically, we don't see it if it's an in-state because we do use the per diem rate, which simplifies the calculation; and it's just, you know, easier for everyone.

MR. COGHILL: Thank you.

MR. PETERSON: Senator Coghill, one of the areas we see a lot of problems in is behavioral health; and that is a difficult area. As you see, I don't have any cases prosecuted yet. Part of the reason for the difficulty is because the regulations are devised in a way to try and figure out who needs behavioral health-type services.

And I guess the looser the regulation is to provide more service to those individuals that need it, it makes it more difficult for me to prosecute because it's not a clearcut allowance, black and white, what is or isn't allowed. The tighter you make the regulation, then the concern is, there are going to

be legitimate people who need the services that aren't.

And so that's one of the issues that Doug and I have been working with behavioral health on a lot, is trying to, you know, identify when they come to us with a concern, saying, "This shouldn't be happening," if I can't prosecute it and it can't be civilly addressed, then we try to sit down and figure out, "All right. How do we stop this and tighten up this regulation so that" -- put them on notice so if it happens again, now we can address it. But that's another area where I think the billing practices are not as tight as you would find in a hospital setting as well.

CHAIRMAN HURLBURT: Any other questions or comments?

Thank you both.

MR. PUCKETT: Thank you for your presentation.

MR. JONES: You bet.

MR. PETERSON: Thanks for having us.

CHAIRMAN HURLBURT: It's been a very interesting day, very informative. Thanks for

what you're doing.

MR. PETERSON: It's actually really fun. I don't wake up any days and not want to go to work. That's good.

CHAIRMAN HURLBURT: Deb, do you have anything before we --

MS. ERICKSON: Well, we probably should go over a few things.

I think we are at the end of our day, so we are not going to spend any time trying to brainstorm at this point. I think our brains are probably fried anyway.

So you all can sleep on this tonight, but maybe we can start our conversation tomorrow morning picking up where we're leaving off right now, if you want to spend some time having a little bit of a conversation both about what some of the significant points of learning that you had from this last session about fraud and abuse -- and this is one of the three areas that we identified, that we wanted to work this year on identifying whether there was some strategies or recommendations we wanted to make.

So did we learn enough today about what's happening with this program to come up with

some potential recommendations, or not? Just be thinking about that overnight. The main point --

CHAIRMAN HURLBURT: And then give us a context in regard to that, which I think is an important part to think about too.

MS. ERICKSON: The broader context?

CHAIRMAN HURLBURT: Yeah. Where the fraud and abuse fits into the overall.

MS. ERICKSON: How it fits into the broader context. Because one of the questions I have for you all, is we put fraud and abuse as an agenda item for this year. We just had a learning session just on Medicaid fraud and abuse. We got a sense of what -- do you want to spend some time this year learning more about what is happening in the private sector, public employers, Medicare? Was Medicaid enough? So that's an open question. Do we need to spend more time learning about it and how much --

MR. MORGAN: Can I ask -- Jeff, do you guys -- I don't know if you can even talk about it. But from your industry in Alaska, do you guys have this kind of garbage going on too?

MR. DAVIS: Yeah. We have a special investigations unit that's law enforcement,

attorneys, and others. And, you know, obviously it works differently; but, yeah, there's enough to keep them busy.

MR. MORGAN: I guess -- I mean, I read the "Anchorage Daily News" every day, and I really don't -- you know, maybe it's because it's not like a plane going missing or something. It doesn't hit the front page.

MR. DAVIS: Well, what I'm thinking of, what occurred to me, looking at the numbers, there's one conviction, one conviction, one conviction. But when you start getting 27 in the first few months of a year, well, now maybe there is something to talk about.

MR. MORGAN: Do you guys -- are you experiencing the same volume?

MR. DAVIS: I don't know, David. I can certainly find out.

MS. ERICKSON: So we can continue that conversation tomorrow morning. Is this something that you all would like to learn more about, what's happening in the private sector, too, and do you think we could add -- as a commission add some value in terms of helping to improve the system by coming up with some recommendations related to

it, or if it's just an interesting learning that we can document and move on.

All right. Should we recess for the day?

CHAIRMAN HURLBURT: So breakfast is at 7:30.

MS. ERICKSON: But we are in the Capitol Building tomorrow. This building will be locked up, and they would not allow us to prop the door open. So our legislative members graciously offered to sponsor space for us. We'll be in Room 106, which is the House Health and Social Services Committee hearing room, if you're used to visiting that.

CHAIRMAN HURLBURT: One flight up from where you come in the front doors.

MR. PUCKETT: Turn left at the top of the stairs.

MS. ERICKSON: And we're told the building will open up -- it opens up at 7:00 on Saturday morning. Does anybody have any questions before we recess for the evening? Okay.

CHAIRMAN HURLBURT: Thank you all.

(Meeting recessed at 5:00 p.m.)

SATURDAY, MARCH 22, 2014
8:00 A.M.

CHAIRMAN HURLBURT: I'd like to welcome everybody here again. Thank you for coming and being here.

And today we're going to have just kind of a recap and a discussion of yesterday. We've had a chance to kind of think about it overnight, looking at next steps, looking at this next year, this coming year. And then we'll finish up on the price and quality transparency issues. And hopefully Jeff will be here, because I think it will be important for him to be here to help us with that discussion, because I think he's in a position or been placed in a position that he sees both sides of the issues and the questions and can probably help with us that.

So, Deb, do you want to go ahead?

RECAP OF DISCUSSIONS FROM YESTERDAY IDENTIFY OUTSTANDING QUESTIONS AND DISCUSS NEXT STEPS

MS. ERICKSON: Well, I started off

by -- let's if I can get this to work. There we go -- typing up some of the notes that I'd taken from the conversation with Commissioner Streur yesterday, so I thought maybe we could start with that and just see if -- I'll give you a minute to look at the notes that I took from that conversation and see if there is anything in particular that you wanted to reflect back on, if there was something that you think is important that you noted as important from that conversation.

So I thought we'd just start with that and kind of move through the day and see if anything on any of the conversations or any of the learning topics that we had yesterday came up for you overnight, after you had a chance to sleep on it, and if there is anything you want to add or clarify from the notes that I took here. And then we'll do some brainstorming about learning around fraud and abuse. Does that make sense? Okay.

So you can see up on the slide the notes that I took from that conversation. One of the things he'd mentioned was the challenge that they have had. And he said specifically that's it's proving to be formidable to come up with all of the data they need to really understand what the

characteristics and needs and available services are for that gap population that falls below 100 percent of poverty. And so that continues to be a work in progress, but that was an issue that he noted. And he explained that we need a delivery model that reaches the most people in the most effective manner at the lowest possible cost. And when we were talking about the plan, he noted that this should not be considered an event or a document but a process.

And the particular focus right now is on rural health systems, the super-utilizers, and prevention, and that what he would identify as low-hanging fruit for strategies that are starting to be implemented or need to be implemented -- patient-centered medical home, behavioral health, primary care integration, and a complex behavioral health collaborative.

Those were the main things I picked up on from that conversation. Is there anything that I noted that you understood differently? And was there anything that you're remembering from that conversation that stood out as really important to you?

Allen?

MR. HIPPLER: Thank you. I recall Mr. Morgan brought to the attention of the commission the timeline under which the commissioner was operating, which --

MS. ERICKSON: Specifically for the Medicaid Reform Advisory Group?

MR. HIPPLER: No, for the health care plan, which I thought that this was --

MS. ERICKSON: I think Dave was speaking to the Medicaid Reform Advisory Group.

MR. MORGAN: Yes.

MR. HIPPLER: Yes. I'm sorry. I'm getting confused here. Yeah.

MR. MORGAN: But if I may interject, now that he's brought that up, do we have a timeline on -- the plan has to be presented, which is a separate track; but it's a big bunch of stuff too. Do we have a timeline on that, when that's due?

MS. ERICKSON: We don't have timeline dictated or mandated to us. I put a general timeline on the -- I think it's the second or the third page of that draft plan template document that suggests that we would have the first complete draft done by June.

So we already have a really good start with laying out all those different initiatives. The next step will be to finalize the list of initiatives and then work with the division directors and program staff to do a little more detailed one-page overview, which provides a little more detail and lays out some major action steps and milestones and the outcome measures, some evaluation criteria.

So I think we're shooting for having that done by the end of June. And then if the commission isn't continued, there at least will be that much in the plan that is documenting these implementation action steps that we see evidence that the various agencies are starting to take, anyway.

Did that answer your question? I mean, it's going to be a process, not an event. So that will be -- so if we have that document complete by the end of June, then it's really meant to facilitate an ongoing process and dialogue more than anything else, so to document for us and for the public what's going on to implement the commission's recommendations.

MR. KELLER: If I can -- these

mikes, they're live. When you push the button, that's mute. If you let up on it, they're live again. I saw Dave struggling.

MR. CAMPBELL: On the implementation, though, on some of this medical that reaches the most people in a delivery model, I wrote down a question yesterday about on-site employee primary clinics, you know, care clinics and places of business. I'm just wondering how many businesses in this state have large enough population bases to actually have clinics. I can see it maybe on an episodic basis but not on a daily basis. I wonder if we have a handle on that, the numbers of those employers. That was on page 13.

MS. ERICKSON: Well, that's one of the things that we might clarify as we talk to employers about strategies that they're starting to use. Folks are referring to this new clinic at Alaska Regional as an on-site primary care clinic, but it's not literally on-site at their workplace. But the employers that are starting to use that -- and I understand the union health trusts are using that clinic now. And they have a special contractual arrangement with the operators of that clinic for special access for their employees at

special costs.
MR. CAMPBELL: Okay. So I misunderstood. I thought it was a confined employer for one clinic. So you're saying a bunch of employers are --
MS. ERICKSON: Are starting to use that new model that has emerged there.
CHAIRMAN HURLBURT: The initial clinic was Carlisle Corporation.
MR. CAMPBELL: Okay.
CHAIRMAN HURLBURT: And they went in and contracted with H2U, which is a associated corporation with the Hospital Corporations of America. And it's a nurse-practitioner-based clinic. So initially, the first clinic -- and I think it's still a separate clinic -- was for Carlisle Corporation. Then Fred Brown went in with whatever it is, two or three union trusts --
MS. ERICKSON: Including the -- Barb, the GGU union trust?
MS. HENDRIX: Yes.
MS. ERICKSON: So I think the largest union for the state employees now is using that.
CHAIRMAN HURLBURT: Yes.

Going back -- and my thoughts overnight on the commissioner's presentation there yesterday -- and I maybe hadn't engaged my mind in it, even what the expectations were and really thinking about what the word "gap analysis" meant.

But as David pointed out, the time frame is very short. But the challenge in terms of gap analysis -- and I heard the commissioner being a little more expansive than that, of being an opportunity to look at how we do Medicaid here.

But with -- as I mentioned yesterday, with the members of that group not really having the kind of a background -- and some, like Gene Peltola, who certainly has a lot of health background, of course, engaged from the tribal health side in Medicaid and billing for that. But there are others that don't apparently have that background.

And so I see the risk that if Gene at least, put -- for example, to pick on him, because he's wearing his old hat as Y-K CEO -- it could be, "Why are you out of your mind and not accepting all this free federal money and expanding Medicaid?" And that becomes the argument and the focus of attention, whereas I think Commissioner

Streur articulated that it could be a chance to look at how we do Medicaid in the state in terms of quality, in terms of cost.

And, for example, he said that -- used the 140,000 number which, in my understanding, is an incidence number over the year, rather than a prevalence number, meaning that the actual number of enrollees in any given month is a little bit less than that, more in the 120,000 to 130,000 range. Which means that, if you take the $1.6 billion, your monthly cost is even greater, $1,200, $1,300 a month.

And then I compare that with -- and that's for all enrollees. About 25 percent -- and I should know what our number is here -- but normally about 25 percent of your Medicaid enrollees are going to be your ABDs, your AH, blind, and disabled; and they're going to be very costly individuals. About 75 percent will historically have been young women of childbearing age and kids, and they tend to be fairly cheap as far as the dollars that you spend. The biggest expense is going to be just the OB cost, which will be high but not that high.

So if we're spending $1,200,

$1,300 a month for all comers, I think back to the contract of five years ago, and it will be a little bit higher now -- that for the nonABD group -- and there was one significant carve-out in that it extended -- inpatient mental health care was done in Western Washington Hospital, which was a state-run mental health hospital there, and extended behavioral health services beyond 20 visits a year, I think, were carved out for that. On the ABD group, it was just the hospitalization; but for the nonABD group, we did it for about $180 a month. And that's in the realm of $1,100, $1,200 we're spending for the ABD group, which was the most challenging, we did it for about $800 a month.

MS. ERICKSON: Is that difference due to economies of scale, do you think?

CHAIRMAN HURLBURT: Is what?

MS. ERICKSON: Due to the economies of scale?

CHAIRMAN HURLBURT: No. I think that it was pricing and it was medical management. I don't think it was --

MS. ERICKSON: Having a larger patient population?

CHAIRMAN HURLBURT: Yeah. But, anyway, the reason I say that, I think the opportunity, as Commissioner Streur described it, is to look at: How do we do it in the budget environment that we exist in where a third, say, of the Medicaid dollars are state general fund dollars, that there is the opportunity there. But I don't know that that group is structured -- and that there will be enough time to get that background to really be useful and helpful to the governor and to the legislature in identifying the opportunities and options that we have.

So that was kind of my thinking last night. It could be a real opportunity for us, but just based on time frame -- and the individuals who are appointed are bright people. They certainly can learn all this, but I don't know if it's realistic to have then be able to do that by September.

MS. ERICKSON: Well, one thing I wanted to clarify, too, just so -- I was afraid I was going to be causing some confusion here. The Medicaid gap analysis is not part of the charge of the Reform Advisory Group. It was a charge given to the department that the department was to have

accomplished by now.

CHAIRMAN HURLBURT: Yes. I misspoke.

MS. ERICKSON: And so I think that was part of it and part of the explanation that it's still a work in progress and it's proving to be a challenge.

And I took it in part to -- maybe I was reading too much into his comment, so we will have to clarify this with him. But I'm assuming that, at some point, the department might come back to us -- Commissioner Streur might come back to the commission and ask for some help with trying to identify the gaps that they have in information about the gap population. I don't know if he meant to suggest that or not. I was hearing that when he mentioned it, so we'll see.

I know that there are folks still working real hard on it, and that they have compiled a lot of information. It's not that there's nothing, but they -- my understanding is, they still are not -- have not answered all of the questions that the governor has about those -- that population, those folks. So they're still working on that. And when it's done, we'll see it, whether

we're asked to help with it at some point or not.

Dave?

MR. MORGAN: That's what I heard too. It's almost like all hands on deck kind of -- this commission has spent a lot of years -- it seems like decades, but a lot of years having all these reports and going through all these numbers and looking at all these moving parts.

I think -- sometimes it's a flaw in my character, but I tend to look at systems, not necessarily at Medicaid, because the way this state is processing health care is, like I said yesterday, we basically have a solar system with four large planets, and each of them are affecting the orbits of other ones. And that's VA -- and one thing I'd like to mention, which I think we probably haven't talked a lot about. I'm hoping, if we get the person that I think has been offered the slot on the commission from the VA, who actually works in the area I'm about to talk about -- you have 80,000 veterans in this state. By the way, almost 28,000 of them are tribal. We have the highest number per thousand veterans of women in the United States, and we have almost 40 percent of these 77,000 not enrolled in the

health -- for their health benefits under VA.

And I think we have some bleeding going on here, especially with the homeless, which I'm looking at. Anchorage's plan -- they're doing a health plan, too, which I shared with Deb yesterday. I came from that meeting on Tuesday to this meeting. And that's one of the major problems, is dealing with the homeless. And we're starting to find a lot of them are veterans who have veteran benefits who have been honorably discharged.

So you've got all that going on. You've got that planet kind of going through. Then have you Medicaid. Then have you state government and tribal. The rest of it is kind of moons, but the rates, access, and the process are affected by these big planets as they're dragging the solar system through this constellation.

I don't think you can actually address or reform Medicaid without at least understanding its unintentional effects or contexts; but also, we don't have a huge number of individuals up here, if we count everybody. 800,000 people is not a lot of people. I mean, it really isn't.

So we have a lot of access from community health centers that have about 150 clinic sites in some of the most remote parts of the state. You've got tribal that overlays that, but you have a third of those that are not tribal. Then you have the VA. Then you have Medicaid spread across this. They all have different compliance systems. They all have different concepts of reimbursement and how they do it. Even in Medicaid, tribes are reimbursed differently than nontribal entities if they are doing it in their facility.

So you have all these moving parts, and then we've got some nooks and crannies that there's some access problems, especially in behavioral and mental health and substance abuse. And then we have a cost problem and a budget stability problem. What's not to like? You know, this is like putting Europe back together after the Napoleonic wars. You know, it's like, hey, you know.

So as this group is doing their stuff, the advisory group, and as you guys in Medicaid and public health -- and I left out public health. We have four metropolitan areas -- really

three that do have public health or rural health departments that's doing some stuff. We have a lot of assets. I just don't think we've leverage them right. And somewhere, somehow -- and maybe the plan is -- you know, maybe the plan is the place to do that, but we've got to put it together. And it's going to take some legislative stuff, especially on the reimbursement end.

I personally have come to the conclusion -- I did last night in the Baranof bar -- that I think the only way to really start working the high-utilizers -- and where I worked at, which was a medical home for the last five years and impaneled and had a system, that began to -- it's now beginning to control costs -- is, we're going to have to look at that -- and I know I'm a broken record -- that 15, 20 percent, and look at how we are treating them and how we're -- what we're buying for them and how.

And we're just going to have to look at a case-management-type program for just those patients, not all the others that are low-utilizers, like North Carolina, who came in here a year and a half ago, that basically wouldn't -- you know, a single physician could get

into the web and do case management for individuals with diabetes.

So, I mean, we have some tools. We have some technology. I guess -- and I guess what I'm saying is, we're going to have to put it together. But after three years of going through this, I think it's finally time where we're starting to list stuff, which we are, of what we think we should do or recommend that we're going to do.

And we're going to have to help this Medicaid Reform Group if they're going to make their deadline, I think. I mean, we're just going to have to, as much as they'll let us. I think they'll let us, you know, if we show up and try to help them.

But we also have the gap -- the department has the gap analysis, and we've got all this stuff going on. And so it's basically time to sort of man up, and we're going to have to finally make some decisions and make some hard recommendations. And some of them aren't going to be popular, and there's going to have to be some legislation via Senator Coghill and Representative Keller, and there's going to have to be a bunch of

new regulations or changes in order to meet that goal.

Because I -- the alternative route is so Draconian and so awful that I don't think any of us would want to do that. I thought this would start getting easier. Now it's going to get real hard, I think. But, you know, that's my story and I'm sticking to it. Luckily, there is not that many people here, so I can deny all this. No, you're transcribing it. Never mind.

MS. ERICKSON: You're being video recorded as well, and it will be posted on the web.

(Laughter.)

MS. ERICKSON: Yes, Emily?

MS. ENNIS: I continue to have a concern about a group that are or could be labeled the high-fliers or super-users, and these are the individuals that are using long-term care, you know, every single day of the year at a really high price tag. You're looking at $150,000 to $300,000 a year. And I don't know if that equates to that emergency-room-user that goes every other day, but these are high-cost services that are being provided, and this need is growing.

And when we talk about the

Medicaid Reform Group looking at the cost, I can't help but believe this is going to come under the microscope. And we are challenged by areas of reform, because they are not in hospitals or nursing homes, because we have these community long-term care services; yet they are quite expensive.

I'm also equally concerned with the idea of reforming a long-term care system that isn't adequately prepared to address our seniors, the elderly that are needing those care services today; but definitely, over the next ten years, we're going to see a dramatic increase in that need and that service cost. And we really have not designed that long-term care system for our seniors, and yet we are looking at reform today.

So it's a concern that we really have, for many, many reasons, somewhat neglected that serious increase that we are going to see in the next ten years.

CHAIRMAN HURLBURT: And that, to me, in some of the things I've talked about -- I see plenty of models that we could look to, learn from, adapt, and adopt. But what you're describing, I'm not aware of real good models anywhere; but we have

to do it, because it's a such a huge problem that's growing. And these are people that really have needs, too, that we want to attend to. But I don't think anybody that I'm aware of -- and you're aware of more things than I am -- but it's a dilemma that nobody in our country has really solved very well.

MS. ENNIS: Absolutely. And in other states in the Lower 48, there have been collaboratives and partnerships with even local municipalities, you know, counties, to develop and support the cost of these long-term care facilities and services.

In Alaska, we have not seen a model yet that works; and it's really, you know, due to the high cost of development, high cost of land and construction. We don't see local resources being put toward that to any good extent, any significant extent; and we certainly don't see commercial developers coming to Alaska to make some money in this new business. I mean, there is no money to be made in it.

So you're absolutely right. There are some models, but we just simply can't replicate them here in Alaska for many reasons.

MR. KELLER: One model I think we

don't want to forget is the personal care attendant model that I think is developed further in Alaska than anywhere else.

And we had that briefing yesterday on the fraud control problem that we have here. That really encourages me that we're pursuing that, because that system has to have credibility; and it is a model that really answers having the facility being able to assist families that can't afford to take care of their own, you know, by giving them a little shot in the arm. To do that with accountability is really tough, you know. And that's what the legislature looks at, is we're not just writing this huge check unless we can see what -- you know, what the results are and that it's accountable and everything.

And then going back to -- as long as we're talking politics a little bit, Dave said some of the stuff won't be popular, and it's going to be a lot of work. And I assure you that's the truth. I think everybody on this commission -- I'm guessing -- but just about everybody I've ever ran into is excited and enthused and encouraged when we hear things like telemedicine, you know, and all the things that can be done there. Yet when we try

to do something, part of the commission here has to help, because we have to deal with just continuing -- it isn't something that's going to happen overnight, but that change and the transition is a tough one.

There's two bills right now, one in the House, one in the Senate; and we're really getting hammered, because it addresses the telemedicine aspect. And part of the reason it gets hammered is because the legislators don't have enough information, and so we step in areas where we shouldn't inadvertently. But, you know, I really appreciate that's going to be a focus of the commission, how to interact and how to provide the information back to the legislature and maybe how to help advocate for the things that we dare advocate for.

MR. PUCKETT: I'd like to just add on to Emily's concern for the plans that the division I work with administers, the long-term care plans. And I don't know the demographics for the state of Alaska. I know it's pretty serious. But with our demographic for the long-term plan that we administer, we have a huge problem facing us, and it's going to be within the next ten years. The

numbers are pretty staggering for people that are already enrolled in long-term plans that we administer, that are not using the services yet. And yet their age group is such that we know they're going to be needing it here soon; so just to add on to her concern.

There's only two things that cause me to lose sleep with the job that I have. One of them is the retiree payroll going out late. I just shudder to think of all the retirees calling the division if their check doesn't arrive on time.

But the other one is the long-term care numbers. Emily and I have looked at those numbers, and it's really staggering the number of folks that are going to need the services here in the next decade. And right now, as Emily said, the situation we have in this state is completely inadequate with the current problem. And to think of all those people that are going to be coming up in the next ten years, it's kind of scary.

But it's a challenge that I think we can make, but it is staggering what's out there.

MS. ERICKSON: Any other thoughts from the conversation with the commissioner from yesterday morning that you wanted to reiterate,

reinforce before we move on? And we will to move on in just a minute.

MR. MORGAN: Like a lot of us here, I've also worked in the rural parts of the state for several years. One thing I thought of last night, especially on the long-term issues -- in fact, I gave a presentation to the previous setup of the commission on greenhouses. That was the first time I came before -- not this commission, but there was a previous commission.

And I've noticed, especially traveling around lately, that a lot of the smaller hospitals of 20 and 30 to 40 beds basically don't fill those beds. They'll have three to five individuals in the hospital. Mainly they are transitioning out to their tribal, to ANMC, or to Providence, or to Regional, or transitioning back; one or two emergencies; and usually a couple of moms or moms-to-be.

I've never really understood -- I do know, from a finance side, that there are states that use the fully qualified health center cost report, which can be used in that situation. And maybe we should kind of get that inventory of unused beds and see if it's -- I know, especially

tribal or individuals locally from Dillingham or wherever, would rather stay in their community and not necessarily come in, because the facility is already there. And there's already some infrastructure there. Maybe the most cost-effective way is to utilize those unused buildings that were formerly small hospitals and do some regulation change, if possible, or even some legislation to set up a reimbursement method that way. Because that way, the heavy fixed costs of getting land and buildings is out of the way, and we can concentrate on sustainability and funding the operations for those four or five or eight individuals that need long-term care. But at least look at if it's a possibility of doing assisted living in those facilities or long-term care in those facilities. Like swing beds or something. Do you know what I'm getting at?

CHAIRMAN HURLBURT: That's kind of an expansion of the swing bed concept --

MR. MORGAN: Right.

CHAIRMAN HURLBURT: -- going from skilled nursing to the long-term care.

MR. MORGAN: Right. But you have a hospital there, operating. You may not be

delivering heavy medical; but at least, in the short run, you wouldn't have to build a building, get the land. And probably a lot of individuals would rather stay where their grandchildren are if they're at least given that option. I'm not saying it's a plan; I'm just saying maybe we should at least do an inventory and see what we've got and what would it cost to do it and what reimbursement on a cost report basis. They all have to file audits, you know.

In Indiana, in the Midwest, how they got around the high cost of cost reports was simply make it part of their audit and have a fold-out sheet, like an FQHC cost report, a simple cost report to come up with the daily rate or the encounter rate. And they have to have an audit anyway by a CPA that's approved, you know. He's there. The books are there. Just add a few more pages. It's not like doing Prov; it's doing the hospital in Kodiak or in Dillingham. It's not a way -- we're not going to find the magic bullet. We're going to have to come up a whole -- with six or seven bullets to do this stuff, I think, and make sure it has sustainability and that we have some handle on the costs and controls. It's just

an idea to throw out if we want to look at it.

MR. KELLER: If I could, help me envision the plan again. I know we have that task in front of us, but, you know, I guess I have a hard time defining just exactly, you know, what it is that we're going to do.

In my mind -- you know, I don't know how far off this is, but I see us taking -- going back and looking at our recommendations and the things we have done in the past. And then, with that, maybe have six or -- and maybe you've already said this. I just need to say it in here a couple of times in order to get it, but have six or seven or ten or twelve, whatever it is, bullets, and then have action steps that we are, as a commission -- priority one in this area is to do this, you know, and these other things need to follow. Is that what we're doing? I mean, is that the idea?

MS. ERICKSON: Yeah. And if you want to look at something really tangible, it's in the notebook behind Tab 2. In the very back of Tab 2, this document lists the initiatives that we've been compiling with the division directors. Right now it's titled "Transforming Health Care in

Alaska," but it's focused, at least at this point, on what state agencies are doing and can do to implement the commission's recommendations.

The list has gotten really long, the list of initiatives in here. And right now it's just a list with a one-sentence description of each of the initiatives. The plan is to use the template that's on the very back page to do a one-page summary action plan for each of those initiatives.

So it would include a little bit longer -- maybe a paragraph instead of a sentence -- description of the initiative and then lay out the major action steps, just three or four or five, with major milestones for being able to measure whether the initiative has been fully implemented or not and also outcome metrics to be able to evaluate whether it's having the intended effect or not over time.

So this is what we've drafted so far. One of my concerns is, the list that we've come up with, just with the few division directors we've met with -- we have met with the significant ones, the ones responsible for the most amount of money in the state so far going to health care.

But it's a really long list, so what we might need to do as a group is to prioritize what this group wants to document and track.

MR. KELLER: Sorry to make you repeat yourself. I need to hear it a couple times.

MS. ERICKSON: Don't apologize. We have so many moving parts and pieces to our process. And folks in the audience watching might not be aware, either, of something we've discussed in the past.

MR. COGHILL: Good morning.

MS. ERICKSON: Good morning, Senator Coghill. We saved a seat for you.

CHAIRMAN HURLBURT: Good morning.

MR. KELLER: We were waiting for your comments.

CHAIRMAN HURLBURT: How was breakfast?

MR. COGHILL: My apologies for being late.

MS. ERICKSON: Yes, Keith?

MR. CAMPBELL: It seems to me that if we're going to go down this road, we need at least --

MS. ERICKSON: Keith, could you --

MR. CAMPBELL: Oh, I certainly can.
It seems that we need a list of the regulations that would have to be abated to allow something like this to happen because, in my experience, every time you try something new, somebody says, "Well, you can't do that" because you've got -- you're handcuffed by all these regulations. And until we know what -- under this broad topic what we're dealing with, regulation-wise, I think that we're going to run up against that wall every time you go to some of your colleagues in state government particularly. "Oh, we can't do that, because it's against some regulation."
And I don't have an idea how many regs we're talking about, but I know there would be a substantial number.
MS. ERICKSON: Just for Senator Coghill's benefit, we have spent the last 45 minutes reflecting back on the conversation that we had as a group first thing yesterday morning with Commissioner Streur, some of the issues that he noted that he is thinking about related to the Medicaid Reform Advisory Group.
And I don't know that we noted out

loud yesterday, but you might have noticed that Senator Coghill is one common link that we have between these two groups now, that Senator Coghill is representing the Senate on the Medicaid Reform Advisory Group, as well as sitting on the commission at this point.

And so we talked a little bit about this group's relationship to the new ad hoc, short-term group, as well as broader issues about what the commission's role will be going forward generally.

MR. COGHILL: Okay.

CHAIRMAN HURLBURT: I think that I would agree with Keith's point, that we would want to be cognizant of what the regulatory constraints are and where they may need to be changed. We would also want to see what the financial analysis is, because it's not cheap to do things in Naknek, the old hospital where I was, and we cringe when we hear the $140,000- or $150,000-a-year cost that Emily mentions.

But you know, using the empty beds at Naknek -- where we had an average census of 25 50 years ago, and now, as you say, it's about four or five -- because of better housing, better water

sanitization, immunizations, all those things, more jobs -- that we would want to look at, because it could be something that could help support the economic case for having a hospital in Dillingham, which the local people really want to have. But it's also possible it could be a real zinger that could hit us. We could say, "Oh, my gosh." You know, "That's not doable." So I think that's got to be a part of looking at it as well.

MS. ERICKSON: I wanted to see if anybody had any follow-up thoughts related to employers, just real -- the conversation we had about private-sector employers, or employers generally, public sector too. But the conversation we had about the survey that the Department of Labor and ISER is doing for us right now, either specific to that or just more generally to the role of the commission related to working with and supporting and engaging employers and improving employee health management.

Yes, Jim?

MR. PUCKETT: We've talked about it a lot, many times; but the fundamental thing that has got to happen for the employers to get more value for their health care dollar is, the consumers

have got to have price transparency. Without that, then the dynamics of supply and demand really aren't going to be able to work.

MR. CAMPBELL: That's true; but in the bulk acreage of this state, that isn't going to work in its best case, because there are no choices. It might work in the three biggest or four biggest population centers, which, of course, is where the big dollars are. But the fact is, if you expect a free market to work in Naknek or even Seward, you've got a big problem, because the access just is pretty darn limited now for any competition's sake. So I think we ought to recognize that going in and concentrate our efforts on -- these efforts on the major population centers.

MR. PUCKETT: You know, I recognize that there is a problem there. Even here in Juneau, where I live, there are limited choices. But where we do have the choice, the consumer can't make a choice until they know what they are comparing it to in prices.

MR. KELLER: If I could, I just couldn't agree more that this is a key for health care reform. Even though what you say is very, very true, there are only a few of us up here, and we're

a long ways apart. We can get around a lot differently now than we could.

And I just want to comment, from my own personal observation, we've done a terrible job on price transparency. I became -- as I told the commissioner, I became a medical tourist here last interim. I still do not know if I saved the state money. I think I did, you know. I'm not even sure yet what I paid.

You know, that's a problem with this third-party system. I don't know the value of what I buy as a patient. And until we get to the point where it's my money that I'm spending for my health care, you know, we're going to -- I mean, I don't know. It just seems like an impossible, uphill battle to me.

So, you know, from my perspective, this idea of price transparency -- even though I don't have the silver bullet of how to get there, you know, it just seems like that is something we can't overemphasize, in my mind.

CHAIRMAN HURLBURT: I think it makes it more like other economic models. And, by and large, those economic models worked well for standard of living. Compared to what our

grandparents had, it's awesome.

And so I think that we need to get there. And I think that, in looking at the state as an employer and then including the retirees, Jim has got the number of lives to deal with within the state that no other employer will come close to. But you also have the political constraints on how -- if you're a BP or a Conoco or a NANA, you have plenty of political constraints there. But I think that those employers are able to deal with them a little more easily, a little more nimbly, than those subject to the political structure of the state.

So I think that, kind of in response to what Deb said, in looking at employers, you need to lump the state with other employers in that, but there will be a difference. I think the group of HR directors that Deb really stumbled on and then got both Deb and me hooked into is a very useful contact. And I think that we can continue to work with them, be a source of information for them. And then, in turn, they may be able to do some things that can make it more possible for Jim and DRB to do some things.

But I agree. The transparency has

to become a part of it. And I think a mandated transparency I do not see as being the same kind of thing as government trying to operate a system. That is government providing knowledge to its citizens, and I think that's probably an acceptable role for government to play, that we can help foster that as a commission.

MR. HIPPLER: Mr. Chairman, reflecting on your comments and those of Mr. Keller and others as well, you know, many industries have this 20 percent/80 percent split, super-utilizers and everyone else. The difference is, other industries like the 20 percent.

And we have a situation where, for example, as Ms. Emily points out, we're having an expanding senior population. Well, really, this is something to be happy about and rejoice over, that we're having an expanding senior population. And, unfortunately, because of the way the payment structure is set up in our state, that joy comes with a little bit of a cost because, as Mr. Keller points out, some of these people aren't paying for themselves.

I see that as the big underlying problem here, which is really sad, because, again,

it makes something that should be wonderful -- 20 percent of people using an industry heavily -- into almost a perversion of that. We are not wanting people to use the industry heavily. That's all.

CHAIRMAN HURLBURT: But do you have, in those other situations, third-party payers being at risk for the 20 percent? The grocery store likes the 20 percent that can afford to purchase ribeye steaks a couple times a week. The doctors might like it too, but nobody else is paying for it. That's a decision that you make and you're on the hook for yourself; whereas, on the health care side, our mentality is that somebody else is going to pay for it.

My wife's got an outpatient procedure, an extensive procedure -- or rather a procedure that can be done as an outpatient, on Monday. And in asking about the cost, she was told it was going to be over $50,000. And as she kind of pursued it, they said, "Well," you know, "why are you worried? Your insurance is going to pay for it." Jim is going to pay for it. "Why should you be worried about that?"

So I think that puts a little

different complexion on it.

MS. ERICKSON: Well let's move on to just a little bit of reflecting back on the presentation on fraud and abuse yesterday. I just wanted to catch some bullets from all of you and your thoughts about what you felt you learned from that that might eventually, throughout the year, become finding statements for our annual report.

And then if you had any thoughts at all, based on that conversation, if there's anything the commission can do to recommend ideas for improvement. And also I'd like to identify whether -- what questions you have now and what more we might need to study this year to better understand where we are at with fraud and abuse prevention and identification and control. Do we need to learn what's happening in the private sector, for example?

So -- but why don't you start throwing out some thoughts about what you thought you learned yesterday from those presentations.

CHAIRMAN HURLBURT: I thought they did a really nice job for us. And it does give me pause, on the one slide that they showed, that CMS/Medicaid was estimating 3 to 10 percent of

fraud. And I'm not sure what makes up that number. However, what we're actually recovering here in Alaska is still under 1 percent.

And so I really applaud the commitment that Andrew and Doug have and their staff, and I think they need to go after that. We should have zero tolerance for fraud in any business, and my bias is especially in our business.

But that is not where the solutions are going to be. It's not going after bad apples if it's less than 1 percent. It's fee structure, it's how we reimburse, and it's evidence-based coverage and practice. 1 percent of $3 trillion would be, what, $30 billion nationally, taking the whole health care sector. And that's worth saving, and that's significant.

But if 30 percent of what we do either does no good or does harm -- and we will never, ever, ever, get to knowing exactly what that 30 percent is -- but that's a trillion dollars a year. So you contrast the trillion and $30 billion, we should focus on the trillion. And here in Alaska, where our piece rates cost so much, where we pay a lot, we need to focus on a more even

negotiating field between providers and payers so that we can at least get -- initially get to where the rest of the country is.

So I would say that was a wonderful presentation. I'm really glad, as an Alaskan, we've got those two guys doing their jobs. But for me, that doesn't need to be a major focus for us as a commission.

MR. HIPPLER: Mr. Chairman, the 1 percent was the dollar amount recovered, but there are additional benefits to a robust fraud research program, namely the deterrence of other people perpetrating fraud if they know that there is such a thing as fraud investigation -- which, in years past, has not been as robust as it currently is.

So it's true, we may be recovering 1 percent, but how much more are we deterring? And I don't know that I would change anything or do anything more, but certainly I do agree with you that it was commendable, their actions. And I would argue that the impact is a little greater than simply the dollar amount recovered. Thank you.

CHAIRMAN HURLBURT: Yeah. And I didn't speak very well if I left a different

impression, because I totally agree, Allen, with what you're saying. The intimidation part of this, where we may scare folks off from behavior they may be tempted to do otherwise, is worth doing. I agree.

MR. COGHILL: Mr. Chairman?

CHAIRMAN HURLBURT: Yes.

MR. COGHILL: Since that was one of the few things I got to see, so I guess I have some reason to speak on it.

Probably two things came out of it for me. One of them was, in our behavioral health world, there is a transparency issue in the billing. And maybe that's something that we can look into and make a recommendation on, on the process of billing. It may not be that good.

And we're in an interesting time in our behavioral health world right now, and there's going to be a need of some changes anyway. So this may be one key recommendation that will either keep people from fraud or help us expend it properly. So there are the two issues in the behavioral health payment system: one is transparency, and the other is clarity of process.

The other issue that came to my

attention was, he was talking about employers. I'm very sympathetic to employers whose main job is to run their business and try to keep their books balanced; but because of the expectation of health care, we've turned them into health care administrators. And I'm really sympathetic to that.

So the variety of different audits that one might go through really got my attention. So I don't -- because it's both federal and state. And I'm certainly not interested in backing off on the fraud unit, because it sounds to me like we have some issues, but I'm also sympathetic with the employers. So there might be ways that we can help them think through how to line up those auditing provisions so that we don't just hammer them.

You know, in my life in the private industry, I dealt with a range of different auditors, from IRS to environmental regulations to health care regulations to trucking regulations. I mean, it was just -- it was a whole line of audits and regulatory schemes that were required in doing some of the businesses that we did.

And almost every one of them have audit provisions, and we were under continuous

audit from almost -- just name it. It could have been the unemployment insurance people auditing us. It could have been the -- it just could have been anybody auditing us. And we spent probably 15 percent or more of our time and money on just satisfying government audits.

So I'm really sympathetic to those who have to go through that. So, as we were going through the fraud thing yesterday, it just brought back all those memories. And certainly under Medicaid, it's mostly nonprofits, I think, that are going to be dealing with most of these. And their mission is pretty significant when it comes to just having to answer these questions.

So I don't know if there is a way to have a better look at alignment of them, but -- they said they tried to stagger them, but that looks pretty discretionary. And between the state -- right now, they're under a payment problem plan. My heart goes out to my Health and Social Services. But the Medicaid payment plan is a mess right now. And between the audits and the failure of the Medicaid payment plan, some businesses may not make it. So I'm even more sympathetic.

So I just -- I don't know if

there's ways that we can encourage people to line those up so that they are a little more linear, or do they have to be stacked up vertically? I don't know. But I saw that as a problem. Just a thought.

MR. MORGAN: Probably Emily could speak to this, but as somebody who, just a few weeks ago, was a catcher in this ball game while auditors are throwing, one of my sections -- one of the departments that reported to me handled provider enrollment. We had about 400 providers spanning 19 different provider types, from behavioral health to nutritionists to doctors to dentists, just virtually all of them.

As I'm -- every once in a while, a lightbulb comes on. As I'm looking at this process that we went through, the silver lining to the new MMIS system, in my mind, just going through that process, is, this system is so robust once -- and I think they're past at least -- I know in the provider enrollment part they're done -- of fixing some of the glitches.

But it will give them power to really go in with such detailed provider information by facility, program, and reimbursement

methodology, that's going to help in the compliance end, not only in the compliance of what's being delivered, but in the compliance of billing.

Like I said, I've been involved in health care in hospitals, clinics, rural and urban, for about 22 years in Alaska. I have had compliance Medicare/Medicaid calling me to come in and do an audit. I've always been able to work with them and stagger them, and that they understand that simply if you're going to go to Sand Point, there is not enough room for nine guys to blow in. You know, it's simply the logistics of finding the one bed-and-breakfast in January for them to stay at to look at your stuff. So I found, especially in our rural areas, that you can stagger them. They're reasonable individuals.

I think we're going through some pain now with the new MMIS system, and just the part I worked with, which was provider enrollment, is going to give us such power -- Deb is going like this (indicating) -- that it's going to facilitate -- because I don't think anybody wants us to put the provider or the facility through the wringer that's actually -- you know, that's doing everything right. You know, they go in, they look,

and they say, "Well, you should have used blue ink instead of black. But that's okay." I mean, we -- that's not the problem; it's the bad stuff that we heard yesterday.

And I think the system -- although we had a lot -- we're going -- we had a lot of pain, but it's better. But I've done three of these massive conversions -- Kentucky, Indiana, and here. They're always this way. It's not that there's any bad guys in here. It's just when you're changing something with all these moving parts and all these -- you know, all these people and all this money, it always starts out hard. But after a while, everybody actually starts understanding what you got to do to make it run, and you just have to go in there and make your mistakes and learn from them. There is no college course on an MMIS system. You just got to do it and screw up and fix it and move on and get better at it.

I think that's going to empower finding the bad guys and will actually bring some relief to the good guys because they can see that there's no hanky-panky going on here, I think. That's just my personal opinion. I'm not speaking

for anybody else.

When I heard -- when I did listen to them -- and I think it was in this room, except I was back at the back when they were giving testimony -- which he didn't mention -- I thought he had a bunch of pending cases that he hadn't been able to get to. I do think -- I know they got a little extra budget money in the world of not getting any -- in the world of cuts, but I think it would behoove our legislative members not to give them carte blanche, but maybe sit down with them, look at the pending cases, and just talk to them about them. Some of them may be pretty egregious, and you may want to bring in some temp-type investigators to get that backlog out.

But I can't remember how many there were. And there may not be any, but I honestly -- I heard, you know, "Well, I've got 27" or "77 in the backlog that I can't get to."

So I would hope that -- I don't think it's -- the commission needs to get into the weeds on this. I do think we should mention that there are good things that will come out of the new MMIS system. We just got to wait on that. And it will help in compliance, it will help in billing,

and it will help get a handle on what's really going on, whether it's behavioral health or PCA.

Because a lot of the problems are, in some of these programs you don't enroll the individual provider, you enroll groups. And sometimes that's hard to track without doing an audit. I think, under this new system, you can watch it down to the individual provider, even if it's not what we would think is a medical provider, like an attendant, seeing what's coming through for what that attendant did.

So that's the good -- you know, it's been death and gloom and bubonic plague for the last two days, and I thought I would at least give something nice that is actually working.

MR. COGHILL: Actually, I agree with what you're saying. And we get to hear -- as legislators, we get to hear the providers squawking; so I understand that.

So a couple other things that I heard under the fraud was, yes, if they had more people, they could probably do more; and there are probably bad people out there doing wrong things. So as a legislator, I'm open to that discussion. And I think that's going to be important.

And then the other thing that we just don't know is the private industry. We don't know what is going on in the medical world there. And my guess is, they would have to kind of pay for investigations; and I don't know if there is a structure to do that. That would be interesting.

Then the other thing is, they live under federal controls, and are there things that the state might want to do to go beyond what the federal government -- and it looks to me like we would carry the weight of that, but what would be the value of that? That would be interesting to me. If we want to look in on our own medical world, do we want to stay constrained by the federal rules? Certainly we want that federal partnership for their issues, but do we want to carve out something? I think that might be a reasonable discussion.

CHAIRMAN HURLBURT: In my experience on the payer side of private industry, whether it's health insurance companies or property and casualty companies, coverage for automobile accidents, all of the companies have, as a part of their doing business, trying to keep their antennas up, trying to look out for fraud and abuse, because

we have all read about it in the papers. People that have automobile accidents can get snagged by folks that abuse the system and run up the bills.

But I've never seen it be a real big percentage. There are rotten apples in any business, and there are rotten apples in my profession, in health care. But most people, even when they charge high fees, they are pretty idealistic and committed to what they're doing.

But I think the state as a payer for Medicaid, the feds as payer for Medicare, the state as a payer for employees and retirees, needs to be sensitive to that. But I think we're doing a reasonable job. I mean, there are horror stories in addition to just the administrative costs. And I think where CMS -- where we brag, for Medicare, that the federal costs are so low and so efficient, well, they are so low and so efficient because they shift a lot of the workload onto providers and impose a lot of administrative requirements on them.

And Keith is thinking back to his hospital administrator days with your laughter, I'm sure, because it makes a lot of work. And that's a part of the cost.

And then there are also stories that I've heard from my physician colleagues of armed federal agents coming into an office unannounced to do an audit. And maybe the doctor is doing bad things or maybe he wasn't, but -- it seems like that's kind of inexcusable, but it happens.

But I guess what I would come back to is that I don't see this as an area that we really need to focus on a lot and spend more time on.

MR. KELLER: Well --

MS. ERICKSON: Go ahead.

MR. KELLER: I was just going to, you know, really acknowledge your caution. And I think that, in light of things like the evidence-based medicine and the market emphasis and transparency and everything, I think that's true.

And this is an implication of -- I think what you're saying, at least the way I see it, is, that fraud is -- trying to beat out fraud and abuse is more sexy in the sense that, you know, people will get on to a witch hunt and look, you know, really hard.

But reflecting back on one of the

things that was said yesterday that was very -- had me really thinking last night, I think he said -- and I need to get more information from Andrew on this -- but I think he said they're not prosecuting as much in the mental health areas. And that just got me thinking about the transition that we're in as a culture and a society, that we're, you know, acknowledging that mental health is a portal into the health care system, and we have -- I think we have a moving target, both in diagnosis and the -- you know, the definition of the services out there.

So it's just interesting to me that the person that is looking for fraud in that area, you know, is saying that they just don't have -- just a little parenthetical. The standard they're using of beyond a reasonable doubt -- Senator Coghill and I are chairs of the respective judiciary committees -- that's a very high standard, and it's a very shocking thing to see the number of convictions he's getting and how fast that is growing. I mean, that is a huge statement.

And I guess looking at us, you know, thinking about what we can do, you know, clarity on the mental health services I think is very helpful, not in the context of -- necessarily

of fraud and stopping the abuse there, but just being very careful that we don't go further down this road of the implication that, hey, it doesn't matter what the service is. A third-party -- it doesn't matter. We've got to be very explicit in stating the problems. Mental health issues don't have a medical -- a physical marker, you know. And so you get into this area where, you know, it is a challenge for us.

Anyway, I hope that made sense, but I just wanted the chair to know that I hear your plea, you know, that we can't let this become the focus of the commission. It can be a focus, and I personally would argue that it really needs to be a focus, from what has already been said, the deterrence; and I think it also drives us to be more exact in the ways we engage.

MR. COGHILL: Mr. Chairman?

CHAIRMAN HURLBURT: Yes.

MR. COGHILL: A suggestion. And to back up my suggestion, let me explain.

Most of our mental health providers, especially in the behavioral health world, are grant-based and have tried to get whatever they can into Medicaid billing. It's not

worked real well.

It wouldn't be a bad idea, maybe, if the commission could get the commissioner or his designee and the Mental Health Trust or their designee to come and explain to us what that looks like from the ground up on payers.

Because it seems to me that most of what we do in the mental health world is either going to be the Department of Corrections, a hospital entrance, or grant-based services. And I know they cross over between Indian health services and the state health services, but I still think they're mostly grant-based if I understand it properly; and I may not.

But it might not be a bad idea for the commission to get those two to come before us, because I know the DOC bills, but I understand the agencies are the ones that are supplying the services. They may be able to tell us how that actually works from the ground up.

MS. ENNIS: Senator, one answer to that might be the determination of eligibility. Individuals who experience behavioral health, mental health issues similar to seniors with Alzheimer's or related dementia don't meet the level of care

required to be funded through Medicaid or Medicaid waivers. They don't meet the level of care for nursing homes, so the services that they can receive have to be funded by grants or other sources other than Medicaid.

MR. COGHILL: And I understand Medicaid is an institutional model. I understand that. We have waivers. I understand that. But we still -- are still building some services, but that's why I think most of them are grant-related.

MS. ENNIS: Exactly.

MR. COGHILL: And I think that's why our whole system right now is sloughing into disrepair.

CHAIRMAN HURLBURT: So let me ask you a question, Senator Coghill. In what you're saying, would part of this be to help us understand the difference, particularly in areas of accountability, between the grant process and the contracting process?

MR. COGHILL: Absolutely. There are probably three things to look at: the eligibility, as was said; what grants require -- because we all have different categories of grants. You'll have SAMHSA grants, which are federal.

You'll have state grants in a variety of different things. And they are applying for different things, so they probably end up as categories.

That's another reason it's hard to examine for fraud and abuse, because it has to be grant-specific, just like our fraud unit has to follow very narrow rules when they're working with the federal government. So we need to understand categories, and this is one of the reasons why fraud may be happening that we don't know about, because we don't know who is doing what under what conditions.

So it might not be a bad idea for us to hear that out loud. There may be things that we can recommend to both the administration and to the legislature for lining up clarity. It's just a thought for the commissioner.

CHAIRMAN HURLBURT: That's pretty concrete.

MS. ERICKSON: It is very concrete. And I'm just thinking, too, there might be some opportunity for spreading the load a little bit with the new Medicaid Reform Advisory Group. If they take a particular interest in this, if we could bring -- where we are looking at bringing a lot of

what we've learned to that group to help get them up to speed, that maybe they could help inform this group too. So we'll make sure that we're working closely with Commissioner Streur to make sure that we're not duplicating efforts and making twice as much work for his staff with these two groups.

MR. COGHILL: It would seem to me, Deborah, that the thing that the Department of Health and Social Services could bring to the table is how they categorize grants and how they look down through the system to the actual delivery, because I know they have their own audit. I don't think -- I don't know that it's totally an audit system, but they have their grant review system that at least could give us those categories. And then, for us, we might look at how a health care delivery might, in this case, look for fraudulent work.

For example, I know the billing is complex. And because you have a complex billing system, there is always room for places to be manipulative, just like in the PCAs that we talked about yesterday.

CHAIRMAN HURLBURT: Do you want to move on?

MS. ERICKSON: Any final -- yeah.

I think we really need to move on, I think, to our next agenda item. But are there any final burning issues related to fraud that anybody wants to bring up?

I think we're still missing Jeff. I expected him about 25 minutes ago. Could I suggest we take just a five-minute break? I hate to start without him; but if he's not here at 9:30, then we can -- let's just start then.

CHAIRMAN HURLBURT: Surely.

MS. ERICKSON: Let's take a real quick break and reconvene at 9:30.

9:25 AM

(Off record.)

9:37 AM

CHAIRMAN HURLBURT: Okay. We're going to spend the last few minutes this morning on the wrap-up. Now we're going to talk about price and quality transparency issues. We have already touched on it this morning. I think it's something we keep coming back to on that, that this is important for patients, it's important for payers -- employers and others who are payers. And so we want to talk a little bit about where we are, where we're going, and what's on the table here now. And Deb is

going to lead us in this also.

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MS. ERICKSON: I want to point you to Tab 4 of your notebooks. There are some handouts there related to this conversation. And one of the things that I would like you to be thinking about in this conversation -- and if we could end the transparency-specific conversation by no later than quarter till 11:00 and go back and revisit again the conversation that we started yesterday morning about how the role of the commission might evolve going forward, how it should evolve. And I think this is going to be a good exercise to help us think about that because I have questions for you all about what we should be doing next related to the all-payer claims database.

So I didn't repeat it in a slide, or I didn't type it into a slide, but we have a recommendation about -- that the state should have an all-payer claims database. And if you want to look to the specific language of that, it's in the handout in your notebook that lists all of our

current recommendations.

But if I could just revisit that for a minute, the commission -- and we have an even more general recommendation about transparency. I'm just going to read real quickly the whole thing.

The commission recommends the Commissioner of Health and Social Services investigate and the legislature support implementation of a mechanism for providing the public with information on prices for health care services offered in the state, including information on how quality and outcomes compare, so Alaskans can make informed choices that engage consumers.

So we already have that recommendation related to price and quality transparency. So far, it's at the Commissioner of Health and Social Services and the legislature.

And then more specific to an all-payer claims database, the commission recommends that the Commissioner of Health and Social Services and the legislature -- and I can't read this without chuckling -- immediately proceed with caution to establish an all-payer claims

database and take a phased approach. As part of the process, address privacy and security concerns, engage stakeholders in planning and establishing parameters, establish ground rules for data governance, ensure appropriate analytic support, turn data into information and support appropriate use, focus on consumer decision support as a first deliverable, and start with commercial insurer, third-party administrator, Medicaid/Medicare data collection, and then collaborate with other federal payers.

So where we're at right now, when we made these recommendations, we weren't seeing the commission, necessarily, as the place to actually do the policy development work; and we're recommending that the department work with the legislature and stakeholders to do that.

We have had some interest on the part of legislators in this recommendation. And because of that, there are two documents that I drafted that are in your notebook. We were starting to get a lot of questions about "Well, what exactly is this?"

And not that this is -- we've provided a good explanation of exactly what an

all-payer claims database is, but one of the handouts -- I think it's the first handout -- in that section is a two-pager. And I tried to summarize, in just two pages, what an all-payer claims database is and what the major issues related to an all-payer claims database are, what the major concerns might be, in table form on the back of this -- keeping in mind that legislators don't have time to read 80-page reports, which is what we had otherwise for them to look at to try to understand what an all-payer claims database is.

So I've put together this two-pager and have been sharing it with legislators and legislative staffers who ask for a little more information or just wanted to understand better.

I also had been approached by a legislator, who was interested in drafting legislation, for some assistance in understanding what ideally should be included in legislation for an all-payer claims database.

So based on the framework that you all had provided -- and this is going beyond our charge. So this is -- well, I don't know if it's going beyond our charge, but this is why I have a question for you. I wanted to share with you

publicly what I drafted based on what we learned from other states, what we learned from our all-payer claims database consultant, and what you all have laid out as kind of those main six principles that should be addressed in doing it in this other draft paper on elements to consider. It's entitled "All-Payer Claims Database Elements to Consider in State Legislation." And it's still a draft.

So I want to talk to those specifically, those documents specifically. But it's a big question in my mind and one that, at the end of our meeting today, I'd like especially to hear from Senator Coghill and Representative Keller on. Is this the sort of work and help that the legislature expected all along? Would like now? Would like going forward from the commission as to actually, where we're recommending legislation, participate in helping to draft in a little more detail than what we've done so far?

Again, we have other examples of where we've recommended legislation, where we've laid out some major principles, but we haven't gone to the next step of actually doing a more detailed brief on what should be included in legislation.

So that's a question I have in mind, and I just kind of lept forward with it when I started getting the questions. But I wanted to define more clearly for future years if this is a role that you all think we should play and that the legislature wants and needs. So that's the first question that we can use as an exercise for.

Then if -- another question related to that, just beyond writing papers. We've recommended, because we didn't really feel like we had the bandwidth with everything we were doing, to be the convenor of the stakeholder groups and actually implement the stakeholder process. We've tried to limit our role so far in these first three years to being almost like an institute of medicine committee where we bring -- the folks who are at the table are bringing their expertise and their experiential knowledge of the various sectors that you represent and interests you represent to inform a little bit more on an academic -- I'm trying to think of a word that might not be offensive to some people -- but an independent process, where we're looking more objectively at the full system and trying to understand and identify recommendations to benefit all Alaskans and improve the whole

system, and not looking at it from a stakeholder perspective.

So that's been our role so far. And I'm not suggesting that this group change that role, but then should the group start to be a convenor of stakeholders to work on some of these implementation issues? And again, the all-payer claims database would be an example of one of those, assuming that either the legislature doesn't decide to put a stakeholder process in legislation to start the process or if the department doesn't have the staffing and the focus and the opportunity right now to do that.

So those are questions about our role and what process we should use going forward generally.

Maybe I'll stop there and let me ask those questions now and then take comments on the draft. And you've had, as homework, to review that draft legislative paper; so if you have any comments on that too.

MR. COGHILL: Yes, I do have a couple of comments, Mr. Chairman.

First of all, I think the commission has done a good job of identifying some

of the areas that need some work. So I think -- and it is broad, and sometimes it's hard to get your mind around it, and especially if you're a guy like me who gets to show up every third meeting. So my apologies for that.

But I think that identifying -- like this all-payer claims database, identifying the need and the reason for the need is good. I think convening stakeholders is important. So those are both, I think, good ideas.

Certainly if it's going to require a legislative action, it's always nice if legislators can get a body of thought that has industry credibility. You know, the interesting thing for us is we're on day -- in 29 days the legislature is going to gavel out. So with a 90-day session, if you don't have a body of thought that is ready to be debated, it's going to be tough to get it through, especially when it comes to the health care world, because it does have tentacles. It goes into almost every area of the industry.

So I think, like, for example, talking about the government structure, how it might work in Alaska, how it has worked in other places and what those differences are is probably a

good discussion to have in this commission. So those are things that you can bring to the legislature and say, "Here are what we've done with regard to what the providers in Alaska see where there might be some implementation problems in Alaska and how other states have tackled those problems." I think that's a good idea, personally.

MR. KELLER: Can I add to the same thought? I don't think it will take away from it, because it was well said, but maybe just getting a little more explicit.

An ideal situation for a legislator walking into a session is, you know, having a draft of something there that has been vetted. In our case here, like if the Health Care Commission could come up with some kind of language where there was some kind of an understanding and compromise between the Primary Care Association and the Alaska Medical Association, the Alaska State Hospital and Nursing Home Association -- all the groups -- the Alaska State Medical Association -- so that -- you know, the issues involved, where some of the compromises have been made by the experts, by the stakeholders beforehand, that's a dream situation for a legislator, because you go

forward and you don't get hit by surprises, you know, that seem to make complete sense and blow things out of the water.

So, you know, if the commission really wants to help and if there is a consensus that legislation is needed, you know, that would be perfect if, during the summer, we could have some meetings where, you know, there was some give and take with the different stakeholders.

And that's where I started. Remember yesterday? Remember when I said, "Fools rush in"? Because knowing the stakeholders is always a pitfall for us. And we, here in the commission, have access to all of them, you know; so there is no reason in the world why we can't come to terms beforehand. And I think we can move the ball down the court if we can focus on that.

CHAIRMAN HURLBURT: Jim?

MR. PUCKETT: I think we really need to incorporate the health and human resource directors, or that group that recently introduced themselves, because it named all payers. But we've got to make sure we have as many of the employers in the state who are paying the bills involved in what the commission would do, or at least just sharing

what they would like to see done. We don't want to overlook that part of it.

MR. COGHILL: Mr. Chairman, I think that's where convening really comes in handy, is to use this commission as that first vetting. I don't know that you want to come up with kind of legislative -- how do I say this? You don't want to get ahead of legislature, and I think that might be a problem.

So what you want to do is present: In our health care planning for Alaska generally, here's where we see a need. Here's what the players in that need see as a workable solution, or here's what the problems in making that work are going to be. Here's what other states have done.

I think those are really good tools, because what happens in the legislature -- as you say, you will have committees assigned who, every two years, are brand new. And there's a continuity that this commission can bring to vetting -- to put it in context. The commission, under health care planning -- you know, there's transparency, there's fraud control. But under this one place, we see we have X amount of people in Alaska. We know we have health care for every

single one of them. Here is the way that works, and this is doable for tracking and making sure that the databases are simple. But here's the complexity for making it work, so you need a governance structure. Those kinds of things, I think, are very important to bring in, in very clear terms, to say what the industry has brought together. And I think the representative was right. If it gets in front of a committee, and, all of a sudden, you have wars between hospitals that are private and hospitals that are nonprofit and Medicare hospitals over against -- as soon as that shows up, it's not going to go anywhere. And I think this is a good place to vet that.

MS. ERICKSON: And I don't -- I want to be clear, though, too, that I don't think we were ever suggesting that there not be a stakeholder process and that those sorts of conversations occur. That's why we suggested the department play that role.

So -- but what I'm hearing so far is direction, I guess, that the commission -- at least for an all-payer claims database, the commission should play that role going forward for now.

CHAIRMAN HURLBURT: I think it's important to remember the consultant contract that we had with the Friedman Group out of Boston, which probably wasn't -- didn't meet our needs as well as Milliman did, I would say.

But we got some real useful information, and they outlined what others had done. They outlined various options -- you buy in whole hog, you buy in partway -- and that's reflected in cost when you buy in.

This was a January 2014 publication out of Robert Wood Johnson, and there is the All-Payer Claims Database Council that is a national organization that's looking at what is being done nationally. And this has a map. There are 11 states that have an all-payer claims database now, and they kind of range across the political spectrum. They categorize a total of 30 states as either having or are in the process of implementing or having a strong interest in all-payer claims databases, and they include Alaska in that group.

Interestingly, Washington was put in the group in which they said there is no existing activity at the present time. And as I'm

sure you're aware, Washington just went through the process where both the governor and one of the members of the legislature, Representative Eileen Cody, who is a nurse, were sponsoring it. And it had some very strong support from the provider side, from the hospital association, from physicians groups, from business groups, but it ended up with very strong opposition from the two biggest insurers, from Premera and Regis, No. 1 and 2 in there.

And that's why I was hoping that Jeff would be here, because he could share with us on that. Because Jeff was actually the one that made the motion, and I think he was -- well, like he said yesterday, "I represent the health insurance industry, but I also represent all Alaskans." And he may have had the second hat on when he said that, but Jeff is always so objective and willing and open to listen to both sides of the story. I think it would be helpful to get his take on that, of how their company came to the conclusion that probably was, "The Blues are so big that we can negotiate the best deal, and we don't necessarily want to share that information with everybody." I would guess that. But, anyway, that

was a state listed as not being engaged.

So I think there are sources of information -- from the national council, and there are some reports that we have -- that we can look at what's being done, and then I think we need to be a convenor and bring the providers together, as they did in Washington, and get the Premeras and the Aetnas.

MR. COGHILL: I hear you, and I'm sympathetic to that. But as just a citizen of the state and of the United States, I'm not a big fan of a centralized database. Really, I'm just not. So I struggle with those, because if it works from the consumer-based directive, I'm okay. But if it works from the top down, I'm not. And so those are the kinds of things I watch. And we have a privacy part of our constitution that makes it very clear it has to be bottom-up-driven.

So those were the things that, as we debated -- if we got to it in the legislature, that's how we would debate it.

CHAIRMAN HURLBURT: We have one of the strongest privacy clauses in the country, don't we?

MR. COGHILL: Yeah. Right.

MS. ERICKSON: Yes.
Yes, David?
MR. MORGAN: I did do my homework, and I was looking at the Health Care Incentives Improvement Institute score card. And we have a document called the "Health Care Incentives Improvement Institute" that broke down, gave a grade for each state. And it talks about the scope of providers and what they're doing by each state and scope of pricing.
Interestingly enough, in the pricing part, they had charges but they also had paid amounts, and then a detailed scope of services that were included in their document. I found it interesting. Well, Washington got an F, by their standard. But what I found interesting was, Colorado and Nevada got Bs. And I was looking at their categories, and they had it in pretty much everything -- the major diagnoses, inpatient and all facilities -- but they didn't have the payments.
I noticed that the two, Massachusetts and Vermont, that got A's, the only two states that got A's on their website or whatever they present to have this information,

included what was being paid versus what's charged. Sometimes that especially helps in a lot of discussions. I go back to that moment where hospitals were talking about how much they were writing off; but when you actually asked them the difference in what they're writing off in charges versus what it costs, it was significantly different.

I know the health care insurance underwriters and brokers have talked to me, and I've gone -- our last primary care statewide meeting was at one end of the hall of a hotel, and at the other end was the brokers who were doing their state conference; and I was sort of giving a talk at each end of the hallway.

But they voiced to me that they have been trying to get something like this for 15 years. And I asked them, had they actually talked to their legislator? And other one person, their president, none of them had. I highly encouraged -- I said, "Really? It's real easy. Just get on a plane, come down here, or even make a phone call. They'll see you if you give them a couple days' advance notice."

But I think, when we get to this

part of what we're going to do on it, we'll have a lot of the people that buy it, pay for it will be here to do that on the other end.

They had some very interesting comments. But I feel it would be kind of interesting, Deb, to have our brethren in Colorado and Nevada maybe do, by phone or Skype -- I'd like to hear what they have to say about it.

CHAIRMAN HURLBURT: This report here is last March, and Colorado implemented their APCD last summer; so they're fairly new into it there. But it would be interesting knowing -- to see what they're getting out of it. The initial reports that I recall, to me, like the others, were a little disappointing in that it wasn't being used as much as I would have hoped it would be used.

MS. ERICKSON: I think they're still pretty developmental. I actually got a call from the folks in Colorado, because they found our Milliman reports. And I told them -- they were trying to ask me questions. I kept asking them questions about their all-payer claims database. I told them I had all-payer claims database envy, and they said, "We have Milliman report envy."

So, I mean, there are definite

challenges; and I asked them about some of those. And they said that this claims data comes in, and it is really messy. It's really dirty. It's a lot of work to clean. And the way they financed it was with participating members' contributions. There's no state dollars going into their system. And they're finding, early on -- now, they have produced some really good reports.

I shared with you at one point a link to their system, and they're producing some good reports already. And it's not going into the details of where I think a couple of states on the East Coast have been -- started using that, their all-payer claims database, to populate a public-facing website where they could -- you could actually go in and find prices for certain procedures at least by facility. And I think that's a goal of all of them, is to be able to do that.

But they're still producing some really helpful informational reports for the public, I think, but haven't been able to take that next step because it's so much work and therefore so much more money than I think they anticipated to do the data cleaning to get to that next level.

So I think we have a lot to learn from that, so -- but you've answered my question. I'm hearing from everybody, I think, that we should support, as the next step, the stakeholder process and not sit back and wait for the department to have the bandwidth to be able to do that. And I'm seeing heads nodding.

A clarifying question for you, Senator Coghill. When you said we would be cautioned as to not get ahead of legislature, is doing something like this draft paper that describes the essential elements to be included in legislation -- is that what meant? Is that a little bit too much?

MR. COGHILL: No, that's totally appropriate. I think saying you need a governing structure, and here are some of the things to avoid getting into, trying to describe that in law, for example -- you might point to where that might be, you know. So -- because the legislature also is a convening body, you want to set them up for that next convening that says, "Here are the places where agreements have to be made." The governing structure is going to be a big one. The privacy concern is going to be a big one. Cost/benefit to

individuals is going to be a big one. So there's price transparency plus the industry benefit of knowing predictable methods. And I think it's hard to describe in law, and you just need -- don't need to get into that particular element of it. Just give the principles and the needs.

MS. ERICKSON: And then stop short of actually providing draft language? Is that what -- kind of above the line?

MR. COGHILL: Certainly as legislators ask about it, they'll probably need clarification on principles, practices, expectations. Those are the things that I think should come to the legislature. And then after that, how to stay on task. And so I think some of the elements you put in here are good starts.

And then having industry people come to the table and say, "This is how it could actually work," you get kind of an industrial methodology, which is good. Having us listen to stakeholders who are payers and who are consumers of health care -- those are all things that we need to know: How does that work?

And then that's a deliverable that can say, "We've identified a need, we've identified

ways to get to satisfy some of those needs, and here are things that have to happen to make that need happen." That would be a good commission role.

MR. KELLER: Mr. Chair?

CHAIRMAN HURLBURT: Yes.

MR. KELLER: Yeah. I think I might have caused you to say that, because I talked about the language. I just want to say that I really concur. You know, it's the policy -- the legislature has to deal with the policies they make, and we wouldn't want to go in there and be leading on that. I probably just misspoke.

And the other -- the real comment I want to make is, it's interesting -- we got an F on that report card, and we don't have legislation. Connecticut also got an F, and they've got piles of legislation. So the point is, if this is industry-driven, then I think it really has power. But, I mean, it's top down. Even on the level of, you know, trying to find something to do in a legislature that would cause an all-payer claims database is a real challenge.

MR. COGHILL: Mr. Chairman, probably the other thing -- we're probably not

100 percent unique, but we have four very unique parts to our health care industry; and making this work within that is going to be very interesting. Certainly, the private and the Indian health care service is a big one. The public divided into federal and state -- those four elements make this industry very hard to work with, because you have requirements coming at it from very, very different elements.

And so we need to be able to describe that kind of element as we go forward, so I think the governing structure even has to acknowledge that.

MS. ERICKSON: So did you all have a chance to do this part of your homework and review this paper, and do you have any more specific either questions or comments about the current draft?

MR. HIPPLER: Mr. Chairman?

CHAIRMAN HURLBURT: Yes?

MR. HIPPLER: This isn't a draft, but the brief on the page before it, it talks about data versus information. I think that's very important. And there are a couple of comments about a lot of data that's not very useful.

And what I'm looking at -- when

I'm thinking about the all-payer claims database, what I'm thinking of is the end product, and I -- what I would not like to have happen is massive amounts of data that's really not able to be turned into useful information that's easily communicated. And if that means that we only collect information on a few procedures, that's fine with me. I would be completely okay with a few common procedures, say 10 or 12, and collecting data on that, because that would be easily groomed into something that's actually communicated to people and actually has use.

So sometimes less is more, and I'm fine with a limited database that's useful as opposed to nothing at all.

Jeff who -- or Commissioner Davis, I should say, with Premera, has often questioned whether or not we spend this money and create this and then what do we get out of it? Is it going to be of any use? And that's really what I'm focused on, is the end product. Is it useful at all? Thank you.

MS. ERICKSON: Any comments on the paper? Well, okay. That is certainly going to be a work in progress and will just be a starting point

for working with a stakeholder group when we start convening that group, since I'm hearing direction from you all that we need to do that.

Are there -- does anybody have any other questions or comments about the all-payer claims database specifically, because we're going to go to that report that Dave was just referencing next, because it's a different legislative issue.

Yes, Keith?

MR. CAMPBELL: I'm thinking about timetables and how much alert you'd have to give the stakeholders to get this kind of information ready for a meaningful dialogue with whomever. Are you talking about this summer? This fall?

MS. ERICKSON: Well, I would imagine starting this summer. I think it's going to depend on how involved we are with the Medicaid Reform Group, because that's going to probably have to be the top priority.

MR. CAMPBELL: Well, I ask the question because, if we're going to be asking for substantial amounts of information from the stakeholders, it's going to take them some time, probably, don't you think, to get it ready for us. I don't know.

MS. ERICKSON: I wasn't imagining asking them for information but just bringing them to the table to start the conversation.

MR. CAMPBELL: So we don't know what we don't know yet.

CHAIRMAN HURLBURT: I think, based on what you're saying, based on what Allen said earlier, there is a lot of data; and if it's not information, it doesn't do you any good.

Part of what we're talking about, we're going to get to now, I think, with the next topic, in that there is greater transparency so that a payer -- an employer or other payer, like a state Medicaid program, or particularly if we moved toward more consumer-directed health plans, with the consumer more vested in the costs, the individual consumer, information on charges and on outcomes is going to be important to them; but to make that real information is complicated.

Even payers, even large payers, very large payers, will know what they're paying in claims. They'll have their own internal data: What did you pay for your box of Kleenex, or what did you pay for your implant for your hip? But putting it all together becomes a challenge.

And there was a company that used to be known as Eugenics. It was bought by United and now it's a part of what they call Optum. And they're not the only ones that are doing it, but they're well known in it. They have -- they developed the concept of the Episode Treatment Group that you've probably heard of, and that's where you take your data that you have on what the charges are but then look at it globally. What are all the charges for this episode of service?

So then you can look at a given provider and say, in one of the few, rare situations where we really have competition in Alaska -- but in Anchorage, you could look at, say Providence Hospital, and take a certain group of patients for certain kinds of therapy or a certain kind of problem. And, okay, what's the global fee? Maybe Regional charges more for anesthesia than Providence, but Providence charges a whole lot more to use the operating room. Those are totally hypothetical, out of the air.

And you really don't really care so much, but what are the global fees for somebody with a coronary artery insufficiency, and they're needing a stent, and you give it to them? And what

are the outcomes? And your outcomes will, of necessity, have to be somewhat short-term. And some companies try to develop it themselves. Others buy into it. And even competitors of United -- well, from Optum. And I think they've built a reasonable firewall there that, if you're an insurance company, United is not going to access the information you get from that.

But, you know, it goes back to what Allen said. Just data alone is not enough; it needs to be information. That's not the kind of thing that we'd get first, but it's a part of what we need to look at. But even getting just what is the pricing on this, we don't have that now. We don't have -- the employers don't have access to that, and then the patient doesn't have it. And when the patient -- as we said before, when the patient asks the physician, "What's this going to cost?" the honest answer is, "It depends" or "I don't know," because it depends on who is paying, because the rates are different.

And so I think that getting to that kind of transparency for whoever is paying -- for you or I as individual consumers, or for our third-party carriers, or for our employer is

important, but that's not a first step; that's farther down the road.

MR. COGHILL: Mr. Chairman, do you think hospitals will tell us what their payment stream differentials are? I don't know that they would. You know, if they get paid by Blue Cross or by Medicaid or by a private payer, do you think they'd tell us what the payment differential between those three is?

CHAIRMAN HURLBURT: I think that they -- no, I don't think they would; but I think they would tell us what their billed charge would be.

MR. COGHILL: I'm looking at ASHNHA.

(Laughter.)

CHAIRMAN HURLBURT: But particularly in a situation that's more competitive than Alaska, which means like the 49 other states, particularly there where you may have your biggest payer come in, which is often a Blues organization, and they will negotiate relatively favorable rates in exchange for the steerage, a part of that contract may be that neither party will divulge.

Now, some contracts are signed

with a safe harbor clause, and that is, "We'll get your best rates." And there may be a certain amount of trust. Maybe there's some audit on that. That's not an uncommon way of contracting, with a safe harbor clause so that you say whatever best rates you're giving to somebody else, "We'll do that." Hospitals often will not want to do that, because it limits their flexibility in the negotiation process.

But through the transparency laws, it is -- some states have mandated that that information has to be made available. So just like if you shop for a new car, you can go and find out what places charge. The consumer can find out, in those situations, what prices hospitals are charging.

MS. ERICKSON: And that's what this next part of the conversation was meant to be about, and I think that's what the focus of this report is on state price transparency laws that was included in your notebook behind this section that gave us the F grade, along with a whole lot of other states.

MR. COGHILL: If I could have a minute, when we talk to the industry, there's maybe something else we should add to the transparency

discussion. Because if we're not going to get to the differential, maybe we need to have them describe why different values are assigned.

For example, the private payer, who may or may not show up, who is an individual payer, or a contractual payer, and why they have those value systems, because I think, on a transparency issue, that's a reality that needs to be quantified. And I think that, if there is going to be transparency, we need to give them the benefit of saying, "This is why we think this is a value that is good for our business model. And if you want to work with us, here's what that value statement is." Then price transparency can be probably described a little more clearly.

Then the other thing is, I know that I would probably go to John Hopkins or Virginia Mason before I went to the neighborhood clinic if the real value for me was to go to Virginia Mason. And they may actually have some of the same equipment, but they may not have the value of the right doctor. And so those kind of value statements probably have to be part of the umbrella that describes price transparency.

You know, I don't know that we

want to hide under that, necessarily; but I'm just thinking that we might want to give the industry a way to quantify that so that when we are pushing for price transparency, it can fit under a good value system.

MS. ERICKSON: And are you suggesting that we include quality information along with the price? Is that what you mean?

MR. COGHILL: If quality is one of the values, yeah. I mean, it may not be quality; it may be quantity -- for example, a contract versus an individual payer.

So, you know, Providence might have a provider -- a preferred provider contract that gives you one procedure at, you know, say $100. But if you walk in, and you don't have any announcement that you need that, when you walk in, you pay $150 for it, because "We didn't expect you. We didn't know how to plan for you. But on the other, we knew what the general plan was going to be." That's a value call as well as a price transparency issue, and I think we need to give the industry the benefit of having that discussion. That's all.

MR. MORGAN: What I find

interesting, when you look at the Engenics detail, it breaks it out by ICB-9 and diagnosis procedures. And it breaks it out into percentiles -- 50 percent, 60 percent, 70 percent. And then in the back it has what Medicare pays for each one of those codes, so you can mix and match. The interesting thing is, there's many codes in there, especially for the Northwest and Alaska, that there is not enough volume to fill in the row.

I had an interesting discussion with the individual who is the executive director of the NEA trust, and they have been doing stuff like this for their membership, especially on Centers of Excellence and on elective procedures.

CHAIRMAN HURLBURT: You mean Alaska or nationally?

MR. MORGAN: In Alaska, the NEA here, the trust and, of course, the health care insurance underwriters. I would imagine, when this comes up, they'll both be here because they're -- I'd just like, of course, to pick their brains; and it's good.

I think Allen has got a good point. There is no reason to have all 1,500 procedures pulled or diagnoses, just the top 20 or

30. And I notice the ones that got C's, B's and A's did that kind of thing. They didn't scoop it all up. And you do five of this procedure for the whole state for the year kind of stuff. It was the top inpatient and outpatient procedures, some of them the top 20 or the top 10. You know, they had some parameters in there. And that will probably make it a little bit easier when we get into this and do it.

If you pick out a hospital down south, especially in Washington or, just for fun -- it's been a long time since I've been back, but I pulled up our account where I used to work 20 years ago in Indiana. They have a whole web page of quality measures. I think designing of available quality measures -- we are beyond that. I think there are plenty already. You know, there are structures in place to do that, if we want to add that other side of the column, you know.

But I've priced stuff professionally, and especially on elective procedures, it proves out Milliman. I mean, I've -- you know, it will be a knee replacement. It will be $5,000, and then there will be places here or in other places in the Lower 48 that are

10, 15, 20 percent -- I mean, there are huge differentials, from lab tests to knee replacements. And I think that's what we're really talking about, here, electives and those high-volume activities, that all payers have claim bases for what they do.

I'd like to add, just for the record, community health centers have to publish their charges. They're in the lobby, and they're required, to keep their federal money, that each charge has to be within plus three, minus three of what the actual cost is for the procedure, from a cost standpoint.

So community health centers already do this. You can walk in to Anchorage Neighborhood Health or the site in False Pass, and there is a book. And it has what they charge and then what it costs by procedure, by ICB-9 inpatient code.

So we've already sort of got stuff going on. You know, leverage it. Let's bring them in and put them together. It may not -- it's going to be hard, but it might not be as be as hard as we think.

MR. COGHILL: I was only going to say that my description of using the health

center -- and I appreciate putting the prices up, and I want the prices as much as possible. But if I had a heart surgeon in Anchorage that was doing 1,000 heart surgeries a year, and the guy in Fairbanks only does two a year, there might be a value there, depending on, you know, what I want to do, even if the price is the same. I thought I'd bring that up.

CHAIRMAN HURLBURT: Correct. And particularly for complex procedures, there's pretty good data that doing it more often is associated with better outcomes. Not always, but it is -- for less complex procedures, the data is not as solid, actually. It's a little counterintuitive.

However, in addition to the numbers, you really do want outcomes. For instance, Mount Sinai Hospital, which is a large hospital in New York City, was just in the news last week for doing more of certain kinds of heart procedures than anybody else, but it's kind of fraudulent the way they're doing it. They're overdoing it there, and the outcomes were more complex.

So I think that, where you can, you want to get the outcomes information, so if

you're going to have a heart bypass, yeah, you don't want the guy doing -- you don't want to be one of his first three.

MR. COGHILL: And maybe that's a better way of saying what I meant on value.

CHAIRMAN HURLBURT: Yeah, by how many people --

MS. ERICKSON: Quality in outcomes? I just typed that in.

So what we're talking about now -- I just wanted to make sure that it was clear, that an all-payer claims database is something that providers would want to participate in, I assume -- governance, data stewardship, reviewing data on their services -- but they don't have to actually participate directly in the database itself and providing data to the database. It's coming from the payers.

What the price transparency legislation report card is about -- and Senator Coghill wasn't with us, but I think all of the rest of you were when we had the gentleman from the public come testify about a year ago -- it was either our March or June meeting -- and shared his story of trying to -- after having a real

frustrating experience with an MRI that was ordered for a family member. And it was very costly, and it was owned by the physician who ordered the test. And he did all of his own research to gather prices, and how difficult it was to do that. And then understanding, just within a three-mile radius, how much the price for that procedure varied and how frustrated he was with that.

He came here to this body and shared that story and his frustration. I don't know if he said it to the group publicly or if he said it to me afterwards, but he said, you know, "A database might be nice, if we could get that information through a database; but we're probably years away from that. Can't the legislature just pass a law requiring providers to tell us what their prices are?"

And so this is a little different, but it's one of the uses of all-payer claims database, among many other uses for an all-payer claims database; but that's what I believe 40 other states, at least, have right now, is some laws on the books -- and some have lots of laws that might do no good -- or worse, harm -- and I think that was part of this grading system.

So is that a conversation we should include with these same stakeholders? I don't know if it would complicate the conversation, because we're really talking about two different things with the ultimate goal of transparency. But one, it would be a mandate on providers to -- like the community health centers, as just one example -- post the top 25 or 50 procedures' prices.

CHAIRMAN HURLBURT: You know, I think it would be useful to do that. And I'll give the analogy of the hospital discharge database, where we serve that function, where it was voluntary; and the hospital association was administering it. But because it was voluntary, some were opting out. And so two competing hospitals, one of which was participating and the other didn't -- basically, one said, "Well, if they're not going to show theirs, I'm not going to show mine."

And then we got them together, and they both said, "Well, if it's mandatory, that's okay. That's okay with both of us." And so we got -- you know, you might see them as the targets of a requirement, but they were saying, "We can see

the societal value of having the hospital discharge database. And as long as it's a level playing field, and we all have to do it, then it's okay with us."

Then that, you know, diminishes the amount of grief that the members of the legislature will get if you're trying to do something pursuant to that and it's on the table. And that, I think, was a useful role that we played there.

MR. COGHILL: Yes. I totally agree. I totally agree. And I think for many of us who probably would like to know -- for example, for me, in Fairbanks, it may be an $800 ticket to Los Angeles, but it would save me $8,000 in a medical procedure. So I'd like to know that.

MS. ERICKSON: Other thoughts related to transparency? And even more specifically, to a provider mandate?

Okay. Did you have something, Ward?

CHAIRMAN HURLBURT: No. Go ahead.

WRAP-UP

MS. ERICKSON: I think we're ready for wrap-up. I had wanted to have a conversation, but I think we answered the questions about our role going forward at this point in terms of starting to play -- at this point, where we have a pretty good solid set of strategies and policies recommended, but it might be time now to start playing more of a convenor role of the other players that might normally, through the public process, work with the stakeholders in developing an actual policy.

MR. COGHILL: Yeah, but just on that point, Mr. Chairman, if I may.

We don't probably want to lose sight of the overall mission. So as we do the convening, if -- for example, if we're going to convene on a particular issue, whether it be fraud or an all-payer database, just keep it in the context of what we're trying to do. And I think we do a good job anyway, but I still would like to see, if we're going to do a meeting, just do a meeting on a topic, but keep it in context with what we're trying to do. And I think drilling down into one industry segment is probably an

appropriate focus. So if we spent one full meeting on that, it wouldn't break my heart at all.

MS. ERICKSON: Well, I guess that's another question I have, then, in terms of process. Would you see us -- I was imagining that these would be separate additional meetings that we would have. And that as many commission members that could participate would participate, representing the commission, but that it wouldn't -- it would be outside of our quarterly -- these would be additional meetings outside of our quarterly meetings and wouldn't necessarily be an official meeting of the commission, where we would want to have a quorum and might be making decisions as a commission.

Were you imagining that we would do this just in the context of regular quarterly commission meetings?

MR. COGHILL: That would be my thought, is that it would be a quarterly meeting. If we do it outside of it, it's still going to be debated in a quarterly meeting anyway, in my view. So that's why, to me, if we're going to do a quarterly meeting, one of them needs to be kind of that deep drilling on an issue so that everybody is

up to speed.

And I know I'm one of the worst ones. I've missed several meetings, so -- but, at the same time, if you're going to do a deep look into a particular segment like transparency, for example, and what all might be involved in that, and any recommendation that might come out of that, I think a convening of a quarterly meeting, getting stakeholders there, would be a good idea. I think, otherwise, you still end up plowing the same ground at the end.

Anyway, that's just a thought on my part on that, Mr. Chairman. I'm open to discussion on that.

MR. CAMPBELL: Even if it takes a few extra hours to accomplish that at the same meeting.

MR. COGHILL: I think, budget-wise, you might run into some struggles. I always think about that dollar. It becomes worth less and less by the year.

MS. ERICKSON: That's right.

Any other comments, suggestions, or questions related to our evolving role and also our process?

MR. KELLER: Forgive me for stating the obvious, but the role of this commission is incredibly huge, the opportunity is huge, and it's critical. At the legislature, you know, we get frustrated sometimes. We're one of 60. You know, this is a smaller group, and, you know, there is a lot of influence that this group can have. And I just don't think of this as a hoop that we're jumping through. I mean, this is critical. We've got a train wreck coming if we don't do something about this.

MR. COGHILL: Mr. Chairman and Deborah, through the legislature there are several mysteries that we have to live in, and one of them is the health care world. It's just a mystery. And so if we can -- whatever we can do out of this commission to demystify that is going to be a very important role, including the Affordable Care Act as it begins to land on employers and the impacts that it has on our health care system.

Somewhere along the line, as we talk about everything from transparency to fraud, the changing system dynamic under that system is going to be something we have to do whatever we can to demystify, I think.

And then, like I say, the four elements of our health care system in Alaska are unique. And, you know, we have several large hospitals and many small hospitals. We have health care clinics that are public as far as state and federal public, and then we have health care clinics that are federal only and Indian-health-service-driven. All are very interesting.

So any way we can demystify that as we move forward, as well as make those recommendations, I think is just going to be a important part of this commission.

MS. ERICKSON: I've been remembering one of the first products that came out of our first report when we were -- before we were even created in legislation, the first year under Governor Palin's administrative order, was a much more detailed description in our annual report and then in an appendix that described -- it was about 50 pages -- a report that just described Alaska's health care delivery system.

It would be a little bit dated at this point. It's from 2009. But I've been remembering that, just thinking about the Medicaid Reform Advisory Group, and thinking that providing

the first paper from this commission might be a helpful tool, and we can maybe update it.

MR. COGHILL: Deborah, if we can rehearse that in less than 15 pages -- I'm only saying that because of the information flow that comes to the legislature. For those who want to make any policy call, having executive summaries is very important. Having addendums, if there are 50 pages extra, that's just fine. But I think, as a commission, if we want to become a valuable tool, having at the top end the reasons why and a practical flow -- for example, "This is your health care system, folks. And then here are the complexities that you see us working on."

So those are good things for us to look at. And maybe by this fall, it might not be a bad idea -- since we'll have a brand-new legislature coming in, it may not be a bad idea for us to have a conversation in our October meeting or September meeting, whenever that is, to set that kind of a conversation up.

CHAIRMAN HURLBURT: Anything else on that? And we can come back to it if somebody has another thought, a later thought.

We also want to do -- try, at the

end of each meeting, just to have an informal review of what went right, what went wrong, what could have been better.

And I would specifically suggest that maybe we invite, particularly from Senator Coghill and Representative Keller, comments on this spring meeting, on location and on timing. We have four regular meetings a year and then a fifth meeting of about three-quarters of a day or so in September; so that means four meetings in 11 months. If we totally tried to avoid the legislative session, which is so overwhelming for you guys, that would bring us down to about seven months to try to fit four meetings in.

So one of the questions is, all things considered, is it well to continue to try to have a meeting during the quarter -- really the four months that are consumed by the legislative session? And any comments on Juneau or Anchorage? We were here once before, I guess, during the session, and then this year; so two times before and the others elsewhere.

So from anybody, any of the commissioners, what could have been better this time? Any suggestions, and specifically comments

about what has been the March meeting?

MR. MORGAN: Well, I'll go first. I actually think it's a good idea. And the reason is, I came down -- even though I got to see the wonderful city of Sitka, which I greatly appreciated, I got here a day early. When I came down for the primary care fly-in, I came down a couple of days early on my own nickel.

I find just walking around and talking, spending a half an hour, 15 minutes with legislators and state senators, especially those on finance and health and human service types, and just talking to them, flipping through our yearly report -- because they get so much. Unless they're really into this, a lot of people don't really go through every page. Most of us don't, but we kind of flip through it.

I actually think it's a good thing. I think sharing information -- when I had my interview with the legislative auditors, which was -- I guess, as usual, I blabbed for two and a half hours with them. I said a lot of the good stuff that's happened, especially between tribes, community health centers, and the VA, happened in the back of the room during these commission

meetings -- not necessarily formally, but just talking to each other.

And I think we should come to Juneau and talk. Yesterday there was several staffers from legislative offices and legislators that were here. I talked to some of them. Some of them I didn't know until we were sharing coffee. But I think it's a good thing we come down.

I know it's a hassle for you and Wes, but I think it's a good thing. I think it -- we hear what they're thinking and saying and going on, and they hear us. They see what we're doing. And I would even attend some legislative hearings. And it's good for our edification to understand what they're going through and to get outside of our silo.

So I know it's a hassle. It's a hassle for these two guys who are trying to actually do governance. But, on the other hand, I think when you weigh the negatives -- or as my accountant and former teacher used to say, if you weigh the debits and credits in the great book of life, there's a whole lot more credits to do this. And I think it's a great idea. I may be a minority of one, but, hey, that's never stopped me before.

So . . .

MR. KELLER: Well, on that particular topic of having the meeting here, I think it was a very good meeting, very helpful. And I also -- I think Dave said it well. I mean, it's great to be able to come, spend time walking around, sitting in a committee here and there; and it gives us a good reference point.

And I think like Representative Seaton showing up yesterday shows he's paying attention. I didn't ask him to come. You know, I mean, he said, "Here's a group of people that maybe will listen to the concerns I have." And he came over and testified.

And so, you know, I know it's hard to come down to Juneau. It's a hard place to get to, but my knee-jerk is, yeah, it's great. Let's keep doing it.

CHAIRMAN HURLBURT: What didn't go as well as it could have this time?

MS. ERICKSON: Or what suggestions would you have for improvement?

MR. COGHILL: During the legislative session is really tough for those of us -- we've got committee meetings, and the time

pressure is very difficult; so I couldn't make it to both meetings. That's a down side. And it's tough for me to catch up with you. It's tough for me to read through the information. It's tough for me to get ahead of you, and that's a burden to me. I feel bad about not being able to catch up with everybody.

But it's also true that, you know, I'm carrying a judiciary load, I'm carrying a leadership role, I'm carrying several pieces of legislation, some of them controversial, which creates its own windstorm. But -- it's helpful to have the meeting here, but I think the expectation shouldn't be that high during the session as far as trying to reset anything. I think it's going to be hard.

It's a wonderful time for review. It's a good time to include the legislature, if you can get in front of the HSS committees or a finance committee or a budget subcommittee. Excellent time. If you moved it back eight days, you would be able to speak to subcommittees before they close out. So the closeout, because of the 90-day session, now is happening probably earlier in March. And so if you could get here before probably the 10th or 15th of March, you could be

before budget closeouts. That might create other discussions that may be valuable, or at least understandings that might be valuable.

The committee structure is, at that point, where one house is passing to another house policy questions -- that may be more valuable than at this particular point, although this is not a bad point in time for those policy decisions that are happening legislatively.

If there is -- and this is a high-end recommendation from me, but if it's falling within the policy -- or the discussion level of this commission, there might be some testimony on "This is what we have heard in that particular area."

So those are things that maybe us legislators could be more alert to that probably we weren't alert to this time. So maybe the reason for meeting here might be different than you would have on the other three meetings throughout the year. And we might want to think about that, because it's hard for me to ramp up on anything new that's coming our way. So just -- that's a discussion from my perspective, anyway.

CHAIRMAN HURLBURT: Thank you.

Other comments, particularly any suggestions for improvements?

MR. PUCKETT: I think that coming to Juneau, to me, has worked very well. And I think if we just plan two full days, if we don't use all of the second day -- but I think we should schedule a second full day. And if possible, from my perspective, I think it would be more beneficial for the commission in working with the legislators if it's during a Thursday and a Friday or a Monday and Tuesday, two days in a row during the week. Not that I mind meeting on Saturday, but I just think it would be more effective for the commission if it was during the week, you know, here in Juneau.

MS. ERICKSON: And the reason we scheduled it over a Saturday is we thought we would have more of an opportunity to have our legislators participate.

MR. COGHILL: And that's why I was going to disagree with you, Jim, my good friend Jim. I like having to work on Saturday. It's a much more relaxing discussion.

MR. KELLER: Ditto on that. I came pretty much yesterday, and there was a price to pay. And I will be paying it, and I have been paying it.

And, yeah. Please. I mean, that's hard.

MS. ERICKSON: So would one suggestion be that if we meet -- when we meet in Juneau during legislative session, that we meet over a Saturday?

MR. KELLER: Yes.

MR. COGHILL: Yes. And also, if you meet on my anniversary, it's not always that good. Today is my anniversary. My wife is waiting for me to take her to lunch here in a few minutes. That's always a negative, but we can work with you.

(Laughter.)

MR. COGHILL: However, maybe one suggestion. And I'm only -- this is really, honestly, thinking out loud. But if we have invited testimony that is professional testimony, I would ask you to consider doing it on an early evening portion to make sure that legislators can be there, if we have some professional invited testimony that's coming to Juneau, because they may be dually used to work with a legislative committee as well as a commission.

I would only suggest, if we are thinking that way, we do work evenings from time to time down here, and you do lose people's attention,

that's true; so it has to be in the early evening, you know, 6:00 to 7:00 or something like that. But I'm always open to those things if the alternative is not having us there. So just a thought.

Of course, that is making arrangements for legislators, not for commission members generally. So I'm open to you just pushing that off, but I'm just thinking out loud.

Oh, good. That's on the board, "Senator Coghill's anniversary." I like that. Yeah. Let it be duly noted.

(Laughter.)

CHAIRMAN HURLBURT: Preserved for posterity.

MS. ERICKSON: Can I ask a question based on one of Jim's other comments? Should we extend all of our quarterly meetings so we're meeting for a full two days? The first couple of years we had such intensive learning sessions, folks seemed so fried by the middle of the second day that we intentionally went to a day and a half early on.

But as we've evolved to the point where we're spending a lot more time in conversation and in work sessions, is there -- does anybody have an opinion on that?

MR. PUCKETT: This is just my perspective for the group. This is just my perspective. For me to take the time away from, quote, my job and go to Anchorage or wherever we're meeting, I'm there in the afternoon anyway. As the schedules work out, I can't get out of town until later in the day. I'm just looking at it from the perspective of, while I'm there, we might as well just go ahead and continue to do some more work. That's all I'm looking at, is the investment to get there, but make a full day out of it.

MS. ERICKSON: Any other perspectives? I'm seeing at least two other nodding heads. Okay.

MR. PUCKETT: As long as I can make it to Costco to pick up the things my wife asked for, I'm fine.

(Laughter.)

CHAIRMAN HURLBURT: Thank you all very much. We'll adjourn. And I'd like to thank you, in the public gallery, who have been here during this time. Thank you very much for coming.

MS. ERICKSON: Thank you.

(Meeting adjourned at 10:53 a.m.)

C E R T I F I C A T E

STATE OF ALASKA)
) Ss.
FIRST JUDICIAL DISTRICT)

I, LYNDA BATCHELOR BARKER, Registered Diplomate Reporter and Notary Public duly commissioned and qualified in and for the State of Alaska, do hereby certify that the foregoing proceedings were taken stenographically before me and thereafter reduced to typewriting by me or at my direction.

That the foregoing transcript is a full, true and correct transcript of the proceedings, including questions, answers, objections, statements, motions and exceptions made and taken at the time of the foregoing proceedings.

That all documents and/or things requested to be included with the transcript of the proceedings have been annexed to and included with said proceedings.

That I am not a relative or employee or attorney or counsel of any of the parties in these proceedings, nor a relative or employee of such attorney or counsel, and that I am not financially interested in said proceedings or the outcome thereof.

IN WITNESS WHEREOF, I have set my hand and affixed my Notarial Seal this 7th day of April, 2014.

_____
LYNDA BATCHELOR BARKER, RDR,
Notary Public for Alaska
My commission expires: 5/6/2016