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ALASKA HEALTH CARE COMMISSION

FRIDAY, JUNE 20, 2014

8:00 A.M.

FRONTIER BUILDING, ROOM 896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 2 OF 2

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1 care in Alaska, Alaska Health Care Commission Member 2009 -
2 2014," and my connection with Jeff goes back earlier than
3 that, back to about '97 and '98, when Dick Mandsager
4 contracted with me to come up and help with the transition
5 from the old ANMC to the (indiscernible - interference) ANTHC
6 coming in and Jeff and I worked together with the tribal
7 groups then in helping them understand what managed care was,
8 what the contracting opportunities and needs were, and ANMC
9 was the first, or one of the very first places in the country
10 to contract with a PPO type contract and Jeff led them in that
11 and now they're third-party connections -- collections for
12 ANMC are the biggest part of their budget, bigger than the IHS
13 federal appropriation and they would not be able to have the
14 kind of program they have now without people with private
15 insurance, Medicare and Medicaid and so on, but over the
16 years, Jeff, to me, has exemplified what high level executives
17 need to be and ought to do.

18 He has been generous with his time, such as being on the
19 Health Care Commission, but this is just one thing and Jeff
20 has been very generous with his time in providing it to things
21 that make Alaska better, that make things better for Alaskans.
22 He's been highly respected in the community as a health
23 insurance industry executive. He has reached out to providers
24 and developed real collaborative relationships there.

25 So Jeff, you leave a big hole with your seat on the

1 Health Care Commission, but also, in Alaska and I think we all
2 have great respect for you and great appreciation and clearly,
3 you have brought the health insurance perspective to the
4 Commission, which we need to have, but you have also
5 represented all Alaskans. So thank you very, very much.

6 COMMISSIONER DAVIS: Wow, we should just stop there.
7 Thank you so much, Ward. I'm humbled and honored by your
8 words. It has, I've said this before, it has been a privilege
9 and honor to serve on this body. I'll also share with you
10 that when Jay Butler had resigned and we had -- we were kind
11 of at an interim Chair and Ward showed up to one of the
12 meetings, I told my wife, "One of my favorite people in the
13 whole world has just returned to Alaska." I have the utmost
14 respect for you, Dr. Hurlburt and the work that we did in
15 1997, although forgotten by most, was really important, as has
16 been the work since then.

17 So I will miss all of you and go to a great new chapter
18 in our life. One that will be really positive for our family
19 and I think I shared with most of you that my retirement will
20 be short. It's going to be a month this time and then I'll
21 start a new role with the health system in Wenatchee. It's
22 called Confluence Health. It's the very large successful --
23 Wenatchee Valley Clinic took over the hospital when they got
24 into financial trouble and it's a year old and it's a bit of a
25 troubled relationship and so they asked me to come to work

1 with them and help to make a difference there and I look
2 forward to that. We plan on spending the rest of our lives in
3 Wenatchee and so to be able to contribute to that community is
4 a really great opportunity, as well, but thank you all very
5 much and I won't say, "Goodbye," but -- when we leave today,
6 but I'll say, as the French say, "à bientôt," which means I'll
7 see you soon, so -- and we'll keep it that way. Thank you
8 very much.

9 MS. ERICKSON: Well, I have killed another tree, Keith,
10 and you have a pile of papers all in front of you and I just
11 want to go over real quickly what those are, but then take a
12 few minutes before we start the morning's discussion and
13 learning session on fraud and abuse with revisiting a little
14 bit the conversation from yesterday.

15 So what you have in front of you right now is I took -- I
16 took all of the notes from the slides and the flip-chart pages
17 and pulled them together into a Word document and so the top
18 document on your pile should say, "Commission discussion
19 notes, June 19."

20 The last four pages of that document is the raw notes
21 from the slides and the flip-charts. So you can refer back to
22 those if you think I missed something important or
23 mischaracterized something, but what I did was spend a little
24 time last night trying to organize and synthesize all of those
25 thoughts into something that was a little more coherent and so

1 that's the first four pages of this document. We're not going
2 to go over it in detail right now, but at some point today, we
3 might revisit it, if we have time.

4 What I want to do right now, rather than going through
5 this in detail, we have about 20 minutes before we're going to
6 start our fraud and abuse discussion, I want to capture
7 quickly any key take-aways that might just rise to the surface
8 in your mind after kind of sleeping on that conversation
9 yesterday, how your brain might have organized it in your
10 sleep and what you think some of the main points, most
11 important points made yesterday were and we can just -- this
12 can be random.

13 It doesn't need to be -- because we really -- we
14 addressed at least two major topics yesterday, employer-
15 sponsored insurance and also transparency, obviously. So I
16 will organize those -- your thoughts later. This is just kind
17 of a brainstorming session. I don't want to get into -- we
18 don't have time to get into a conversation about any of the
19 points you raise.

20 So if somebody wants to respond and either debate or
21 elaborate on something, a quick point to elaborate, no
22 debates, just brainstorming, throwing out your thoughts. Does
23 that make sense, and I will pull up our slides, so we're ready
24 to do that.

25 So anybody who wants to start -- while folks are

1 thinking, Ward, you had raised a question a couple of times
2 yesterday during -- no -- yeah (affirmative), good, that can
3 come down now, a couple times yesterday during the break,
4 folks were bringing it up to me after the session yesterday
5 and I don't know if I inadvertently dissuaded you from
6 bringing it up because I didn't understand what you were
7 saying, but I wrote it on the flip-chart up here.

8 It was a point that wasn't raised yesterday that -- it's
9 a point that I think is important for us to asking employers
10 because I'm hearing it from them without asking, more and more
11 , maybe we ask in a more organized way and -- and that is what
12 are -- what other business decisions are non-health care
13 providers, employers, making related to employment in Alaska
14 and other business development in Alaska due to health care
15 costs?

16 So I have added that, even though the group didn't bring
17 it up yesterday, as one of the future questions for future
18 discussion with employers.

19 CHAIR HURLBURT: We, also, briefly talked about it with
20 Emily Read, she -- who's here from the Governor's Office, here
21 this morning, and in the context that clearly is the number
22 one priority for our Governor is, and has to be, the economy
23 and that means uniquely energy industry related in our state,
24 where it's 90% of the state's revenue, coming from the energy
25 industry, but this is an economic issue and where we're 21% of

1 our state's gross domestic product, it's an issue.

2 There's a book that I mentioned yesterday, I think that -
3 - and I don't remember the name, but Deb has ordered the book
4 for her and for me to read. Mike Barnhill, the Deputy
5 Commissioner for the Department of Administration, has
6 recommended the book. It was written by an ex-CEO of the
7 Gallup organization and basically, what it does, it addresses
8 what are 18% of GDP nationally, 21% here, the health care
9 industry, what the impact of that is on other industries and
10 it comes out in ways such as Representative Keller and Senator
11 Coghill had to deal with this year, that we don't have money
12 in our state and the Municipality of Anchorage and our school
13 district, we don't have money to give school teachers
14 increases in salary or significant increases in salaries and -
15 - but what's often unsaid, it's because the health care costs
16 have gone up so much, about 15% a year over quite a few years
17 and that's gobbled up all the ability, and you know, Alaska
18 has always valued our educational system very highly and our
19 kids and the future there, but the health care costs are
20 gobbling that up and edging it out.

21 The HR Director for CH2M Hill mentioned in the meeting
22 that Deb and I had with them that when their company looks at
23 the -- it's an oil industry support kind of firm for a lot of
24 what they do, the engineering firm, that when they look at
25 what it costs them to do business in North Dakota, because of

1 health care costs, and where they're doing the Bakken Field
2 development there and the fracking now, it's a lot cheaper
3 than it is in Alaska and that's impacting a company decision,
4 and so I think that this is something that we want to look at.

5 It's, to me, it's another focus of why we need to have
6 strongly inculcated within all of our psyches the concept of
7 evidence-based medicine. This is as a separate thing from
8 pricing. Pricing is an issue and we talk a lot about that,
9 but to make sure that we're doing the right thing, because
10 we're using so much of our gross domestic product. So I think
11 that's a big issue.

12 After -- after we get the book and we read it, if it
13 looks really good, then we'll make that available, probably,
14 in August, if it looks like it's worth your time to read that,
15 but that's a part of the whole dynamic, I think, that we have
16 here.

17 MS. ERICKSON: Go ahead.

18 COMMISSIONER CAMPBELL: I agree with your statements, but
19 I'm wondering if that doesn't imply that every dollar spent
20 into health care goes into some black hole that's never reused
21 in the economy to a large degree. It's all used somewhere in
22 the economy. So it's not a net loss. It's just a
23 maldistribution or something like that. If somebody could
24 explain that to me, I'd like to know.

25 CHAIR HURLBURT: Yeah (affirmative), I think that's true

1 and we need economists to help explain that, but I think the
2 case, from what Mike told me, the case that the book makes,
3 and it is consistent with some other reading I've done, is
4 that it is an either/or to a certain extent and when, for
5 example, when we were talking with this group that I'm meeting
6 with next Friday, including our colleague from British
7 Columbia, and British Columbia, as you've heard me say before,
8 if they spent what America spends for health care, they would
9 be spending in BC about \$25 billion a year more.

10 Now he's a government employee, so he gave a government
11 answer, but I said, "You know, what are you doing with that
12 money?" He said, "Well, you know, roads, schools, things like
13 that." It could be 70-inch televisions sets or trips to Maui,
14 but I think that -- I believe from what I hear, I think the
15 book will help understand that it is and either/or, to a
16 certain extent.

17 Although, clearly, the physician that gets an income fee
18 for service or salary or whatever, the nurse, does go out to
19 Carrs and spends some of that money.

20 COMMISSIONER MORGAN: I can't pass this up.

21 MS. ERICKSON: Quick.

22 COMMISSIONER MORGAN: Okay, quick, what we're seeing is
23 crowding out, is the term. If I don't -- I maybe missed some
24 of this discussion, but I looked at the Hayes Report, which
25 was looking at the cost drivers of education, especially

1 secondary and primary, and low and behold, and nobody's
2 surprised sitting in this room, it was health care costs.

3 Now the column I added to the study, they basically
4 divided the number of staff into their cost per year, but I
5 took, I hate to be back to widgets, but I took the number of
6 kids in the school, divided that into those costs, as an
7 increment of cost, of providing education to those kids.

8 It was really astounding. Half of those school districts
9 were above the average that our friend that used to be a
10 Commissioner spends on administration, very deep, very wide,
11 very expensive health care programs, but they're also,
12 virtually every school district had their own, so they were
13 really losing a lot of economies of administration and that,
14 but basically, the Sunday paper had two full sheets on people
15 wanting more money for education, more money to keep from
16 laying off teachers, more money to expand programs and we're
17 rapidly -- with -- I think it was a \$2 billion hole in the
18 budget, two -- Wes, probably, and John can give the exact
19 number, but I know we had to dip into our savings. I think it
20 was two billion, but I could be wrong.

21 So some choices are coming because eventually, there
22 ain't going to be no more dipping and that's still was
23 constraint and not fulfilling everyone's wishes. It's only
24 going to get worse, I think, not better and so the crowding
25 out choices starts happening and we're getting to the point,

1 and the Municipality of Anchorage was there about eight, nine
2 years ago, where they were having to choose between nurses and
3 the Health Department and policemen or firemen. So we're -- I
4 think we're approaching on the state level, are we going to
5 keep all the teachers or are we going to give increases? Are
6 we going to have bridges? Are we going to have roads? Are we
7 going to have state troopers or are we going to spend more
8 money on health? I don't think that comes to a surprise to
9 anybody, but I just like saying it, more than anything else.

10 CHAIR HURLBURT: Yeah (affirmative), Mark Foster says
11 that has been the driver for the Anchorage School District
12 where he's their finance person now. It's -- last year, it
13 was 17, 18% increase, but the year-over-year average, going
14 back, what 15 or 20 years, it's averaged 15% increase, health
15 care cost, way above the rate of inflation.

16 MS. ERICKSON: So let's let a couple of more folks throw
17 their thoughts in and then I want to do real quick, just
18 around the table, each person's main take-away from yesterday.
19 Did -- yeah (affirmative), I saw Larry's and Allen's hands up
20 a second ago.

21 COMMISSIONER STINSON: I was just going to remind
22 everybody, we don't have a military representative, but if you
23 recall, and I had lots of talks with the Colonel, this impacts
24 the military, how many people they want to put up here, the
25 dependents, which really would affect Alaska to a great

1 degree.

2 So when we're talking about the ripple effect of health
3 care, there's a huge ripple effect, besides oil development,
4 besides other industries, gas pipelines. The military has
5 been one of the stabilizing influences in this state forever
6 and that's -- that would be a real problem.

7 CHAIR HURLBURT: Yeah (affirmative), (indiscernible - too
8 far from microphone).

9 MS. ERICKSON: Okay, why don't we -- Jeff, I'm going to
10 put you on the spot. We'll start with Jeff and come around
11 the table and just give me, without lengthy explanation, one
12 or two take-aways. We'll say, if you have one major thing
13 that you think -- felt was the most important thing you
14 learned or you heard yesterday, and if you have one important
15 outstanding question.....

16 COMMISSIONER DAVIS: Can I pass?

17 MS. ERICKSON: You can.

18 COMMISSIONER DAVIS: I'll come back around, but.....

19 UNIDENTIFIED SPEAKER: Thanks, Bob.

20 COMMISSIONER URATA: Well, are we going clockwise or
21 counter-clockwise? Okay, an important take-away for me was I
22 think that transparency will help our price problem or the
23 cost problem. I don't think it's the whole -- it's going to
24 solve the whole problem, but it'll make it closer to -- it
25 might help follow the typical economic rules that most of our

1 businesses follow, but we have to be very careful.

2 I am not sure that we can have a good law that will cover
3 all the needs, but I think we need to get started on it and
4 it's important to, in my opinion, to have quality, some sort
5 of quality measure that goes along with the data that's going
6 to be exposed and -- and I note that -- I went through that
7 paper in a little bit more detail yesterday, and you know,
8 they talked about doing stars or dollar signs for expensive
9 versus non-expensive, something simple and -- but I think you
10 lose some details in simplicity, but on the other hand, you've
11 got to make it simple, so that people can understand it and so
12 I guess that's it.

13 COMMISSIONER CAMPBELL: Well, I'm struck that the
14 uninsured actually become, and in my experience also, a large
15 portion of the uncollectables in any medical institution and
16 most of those people are uninsured, of course, and if we could
17 find a way to get, push that coverage down to the small
18 employers, you know, at an affordable level, I think that
19 would do a lot to help the efficiency in the process of
20 spreading the costs, so that a large amount of bad debts
21 doesn't land on one or two practices or one or two
22 institutions, particularly if you have large volumes in that
23 regard. So to me, to find a way to get an insurance product
24 affordably to the small employers, that would be a big plus.

25 COMMISSIONER MORGAN: It was all good. I liked -- I

1 thought it was extremely helpful to actually have numbers of
2 firms and what's going on there with a jumping-off point to do
3 some detailed work. I think everybody has -- I think what
4 came out, also, was an appreciation of what we're getting into
5 now, which is some real policy stuff and that isn't done
6 lightly, I guess.

7 CHAIR HURLBURT: I guess, what I came away -- again,
8 reinforced that while conceptually and intellectually, I
9 really think and All-Payer Claims Database would be a good
10 thing, but it once again reinforced for me that we don't see
11 dramatic successes, yet, around the country from doing that
12 and this Pew Trust document that came out was mostly quite
13 positive about it and sounded good, but it was interesting
14 that the main rein that fell in that document was from the
15 Health Care Cost Institute that Deb mentioned yesterday, this
16 new collaboration with Aetna, Humana, and United, where, on
17 the payer side, they're coming together in a non-governmental
18 way to provide that information, but I think the concept of
19 having the transparency of getting the information, and I
20 agree with Bob, it absolutely has to have quality, as well as
21 price there to get at the value equation is -- we think we
22 have a national solution, although there's a long list of
23 states on the list here that are doing it now and considering
24 it, including our name there, but the results, yet, don't
25 prove that to be absolutely slam-dunk what we need.

1 COMMISSIONER ENNIS: I think I would summarize my take-
2 away by saying, it is complicated. We heard that phrase many
3 times yesterday, but I think I was certainly impressed with
4 the truth of that.

5 First, I wanted to say I appreciated Becky's perspective
6 as a new member and she asked some good questions,
7 specifically, the first one, what is the goal of our research
8 and review into transparency and I -- I do think we need to
9 clarify that, particularly as we're thinking of laws or
10 regulations and the process.

11 Secondly, I took away that there is a big human element
12 and consumer responsibility in our thinking, you know, that we
13 need to recognize. I think, again, that's complicated, how we
14 educate, how we make information available and then how do we
15 encourage consumers to do something with that information is
16 going to be a challenge, one that I think we need to start
17 addressing, but again, there are a lot of factors there that
18 we need to consider and then thirdly, I think most interesting
19 for me is to hear David talk about the gaming aspect and Jeff
20 to refer to the competitive aspect of price transparency and I
21 think we need to be realistic in how that does influence our
22 opportunities for success in this area.

23 COMMISSIONER HIPPLER: So Emily just reminded us of
24 something that Becky said, asking about what is the goal, and
25 that's what I was thinking about last night for the All-Payer

1 Claims Database is what do we want to see when this is done?
2 How do we want it to be used and I was thinking last night, it
3 would be nice to maybe have a very limited scope how to base
4 on certain procedures.

5 I think the only things that consumers could possibly
6 price shop for or shop for is -- are things that they can plan
7 ahead and things of material cost and I don't -- it would be
8 nice to know what the usual cost for some routine charge is,
9 but generally, when people go in for a well-child checkup or
10 something like that, they're not going to spend the time to
11 price shop between physicians. It's for larger -- it's for
12 larger procedures and again, only ones that they can plan
13 ahead and I'm wondering if just somebody can't do this on
14 their own, like me, for example.

15 I was just thinking of that. I -- we only need --
16 there's only so many procedures that people will really be
17 able to shop around for and I like the idea of quality, but
18 quality is so hard to capture. I mean, how do you -- how do
19 you figure out what the population base is that goes to one
20 medical care provider and the population base that goes to
21 another medical care provider and somehow -- somehow use --
22 somehow -- some -- equalize them so that you can actually
23 determine if the outcomes for one group, as opposed to the
24 other, are better.

25 It is so hard to do and I don't -- I don't really know

1 how that's possible and if -- I think just giving the prices
2 ought to be enough. When people are buying a house, for
3 example, they don't have quality ratings on houses when they
4 look at houses. They make their own judgment. They know the
5 price and they do a little research and maybe -- maybe the
6 quality on the All-Payer Claims Database is something that we
7 can't reach right now.

8 So those were my thoughts last night about the All-Payer
9 Claims Database and then, Mr. Morgan, I'm sorry, I'll have to
10 join you in your ivory tower here for a second, you were
11 talking about crowding out, because our Chairman had talked
12 about if, you know, if we're spending more on one sector of
13 the economy, what are the effects of that and Ward, you
14 mentioned that it's not an all loss, because for example, if
15 the medical industry is getting a bigger chunk of the economy
16 than it should, right, the medical care employees and
17 businesses are still spending money locally and contributing
18 back to the economy and that's -- sometimes it's appropriate
19 to say things like that in economics and sometimes it's not
20 and I don't want to go too deep into this, but there's
21 something called "The broken window fallacy of economics," and
22 it specifically addresses this question and unfortunately,
23 just to cut down to it, the fact that medical -- the medical
24 care industry spends the money locally or some of the money
25 locally, has no impact.

1 The only thing that matters is the -- are the funds and
2 resources going to the medical care industry efficiently
3 utilized? That's the only question that matters and if we're
4 -- and if the industry's getting more and more, and -- and if
5 waste is going up, that's the only thing that matters.

6 Whether the money is spent locally by the medical care
7 industry doesn't really matter because if we had that money to
8 spend in other ways, it would still go to the local economy.
9 So I just thought I'd throw that out there. Thank you.

10 COMMISSIONER STINSON: I agree with what everybody has
11 said so far. I would like to say that quality -- I know that
12 there are parameters and I know that there are people who come
13 out with guidelines and have this validated through other
14 measures, I'll just use orthopedics as an example in every
15 community, including this community.

16 There are orthopedists who take on the tough cases, the
17 bad cases, the diabetic, badly injured knee, who you know are
18 going to go into the hospital and stay there for a while.
19 There's also the orthopedist that take the young, healthy, 25-
20 year-old athlete knee and basically, that's their practice.
21 If you were to look at quality outcome data, you're going to
22 have very skewed results and that's just based on patient
23 selection, patient population. So like everything else we've
24 been saying, it's not as clear, maybe, as what everybody would
25 think it would be, one thing.

1 Two, with the Affordable Care Act and the way other
2 things are going, these high deductible plans are basically,
3 you were just talking about no insurance people, well, there's
4 going to be -- people are going to have insurance, but there's
5 going to be a lot of under-insurance but then, the flip side
6 of that is it's going to make people more cost sensitive and
7 it already is.

8 It's already -- it already has and from what we've seen
9 and I think it's just going to increase, because of that, I
10 think if we can get to some kind of actual workable number for
11 the 30, 35 top surgical cases or something like that, probably
12 more from -- if we can get insurance data, it would probably
13 be the best way to do it, because that would cut out a lot of
14 the variables about different contracts with different places,
15 with different insurance groups and you need something.

16 You can't say, okay, for a knee scope, it could be
17 anywhere from \$3,000 to \$15,000, depending on, you know, 18
18 different variables. What they want to know is it \$6,500, or
19 you know, whatever it is. People are going to want to see a
20 number. So we have to come up with some way to come up with a
21 workable number where apples are apples and oranges are
22 oranges for all of these different things and I think if you
23 can give people numbers, just like buying a house, people will
24 follow their pocketbook and do what's best for them and make
25 their own choices.

1 As -- and another quality measure right now on the
2 internet is there's about four different large websites that
3 rate everybody now anyway, whether you want to be or not. So
4 there are other resources out there that I'm not sure the
5 state needs to put time or money into that and if people are
6 internet savvy, they're already looking at all that. The only
7 thing that they don't have is price.

8 So I think price would be helpful. Price would be
9 helpful to me, if I was going to -- I've got a horrible knee.
10 At some point, I need a knee replacement. I know -- I have an
11 idea who I think are good orthopedists in town and who I would
12 like to see and if one is going to charge me \$100,000, the
13 other one is going to charge me 50 and I think they're both
14 good, I think I might want to save \$50,000, you know. So I
15 think other people might think the same way.

16 REPRESENTATIVE KELLER: Yeah (affirmative), the bottom
17 line and first off, is I really do agree, price information
18 available to all, yeah (affirmative), I think that's our goal,
19 you know, it's intuitive. All of us know that's what we want.
20 What I was thinking about all day yesterday and last night was
21 the challenge of writing a good law and getting it through the
22 Legislature, you know, I mean, and especially in a case like
23 this because we're talking about, you know, mandating or
24 incentivizing something for the Alaskan people and the Alaskan
25 people don't care.

1 The people that care are the providers that have --
2 you're the ones that have the dog in the fight as far as how
3 to get it. So I think the most important thing to me
4 yesterday, is I took away was the -- that one of things we
5 could do as a Commission, one of the most valuable things we
6 could do is to identify what the drivers, what the incentives
7 are and to -- just to help everybody understand, you know,
8 just exactly how the market is working and how we can provide
9 legislation that somehow addresses those incentives to get
10 something done.

11 You know, I'm convinced that the key, I mean, and I think
12 it's been demonstrated from the information we've got, the key
13 is collaboration and we -- what I'm talking about incentives,
14 you know, the negative one, of course, is you got to do this.
15 You make a law and nobody wants to do this.

16 So you talk about insurance information, it's a bad time
17 for you to leave, Jeff, because what we really -- I mean, this
18 is, you know, in other words, to collaborate between forcing
19 insurance companies to put information on the table and
20 providers, who have a lot of interest in that for their own
21 reasons, you know, different providers, I mean, this is tough
22 stuff and if we don't resolve that stuff, what happens -- I
23 can't help, but think about what happens in the committee,
24 much like the (indiscernible), you know, is you get this
25 battle between the different segments in the health care

1 industry and it kills the process.

2 So if we can identify the drivers, you know, what it'll
3 take to get the providers together to collaborate on how to
4 get this All-Payer Claims Database online, you know, that
5 would -- that might work, you know, and it might, you know,
6 surpass anything that's been done in other states.

7 I can't help jump in on this crowding out, the question
8 he brought up, there's also going to be crowding out within
9 the health care industry. We were -- we've been thinking
10 about this as far as crowding out, you know, education and
11 health care, and I agree, I mean, that's obvious, but I can't
12 help, but think of the -- from the patient perspective out
13 there, if things get tight in health care, who's going to lose
14 and who's going to win and I have the theory, maybe it's --
15 I'm idealistic, but I have the theory that the least
16 prosperous, the less attractive patients are ultimately -- are
17 at risk and if, you know, the push that we've had to make sure
18 everybody is covered is great, but then when we have to start
19 tightening down on the money, your well-off patients are the
20 ones that are ultimately going to come out on top and by well-
21 off, I mean, you know, well, you understand, I think, but
22 we've got to think about that, so thanks.

23 MR. PUCKETT: I think the big take-away for me was the
24 emphasis -- was communicating in our discussion is the
25 importance of the collaboration of all the stakeholders. I

1 knew that, even before I read that paper, but in reading that
2 paper and then in hearing the discussions, that is critical,
3 unless the -- all the major stakeholders are going to be
4 participating in that, it's not going to work.

5 I'm not concerned so much with identifying the things
6 that will encourage that collaboration. A take-away I got
7 yesterday was your statement about the marketplace is already
8 driving, you know, the ACA has shifted the marketplace and it
9 is already showing up. The impact of that is already showing
10 up.

11 Like I think we're going to see that the things that will
12 encourage the collaboration are going to -- it's going to be a
13 variety of them and it's my own personal opinion. I hope we
14 don't have to make some type of legislation to make it
15 compulsory. I think that would be bad law and I know some of
16 you may -- well, you're a government worker and you're saying,
17 "Don't write a law," well, because I have to deal with bad
18 law.

19 Where I work, there is bad law. There is law that was
20 written and we're having to deal with unintended consequences
21 of that law, so yeah (affirmative), because I experience that
22 on a regular basis, bad law and unintended consequences, I'm
23 very hesitant on automatically coming up with some type of
24 legislation to help us with the development of an APCD.

25 I think the marketplace is already working that way and -

1 - but the collaboration is critical. That's the first take-
2 away. I'm also not too concerned of the challenges because I
3 think it was Thomas Jefferson, and I can't quote it, but he
4 made a comment about collective wisdom is much wiser than, you
5 know, anything that you find in an individual or I think just
6 all the stakeholders can come together and work on this, it
7 will be a product than, you know, any one person could come up
8 with.

9 Somebody in the group, I don't remember who, made a
10 statement, and I can't quote it, but it had something to do
11 about we can take this in small bites, I believe is what they
12 said, and I'm a firm believer in that, I mean, I -- I really -
13 - that caught my ear because a number of things that I've done
14 in my career that was a major change of some sort, I found
15 that taking it in a phased approach usually gave you a better
16 result than if you tried to do the cut -- burn and slash
17 method of making a major change and to develop an APCD is
18 going to be a major change in the health care industry in the
19 state of Alaska.

20 So a comment from one of the Commissioner members here
21 about we can just do it a bite at a time, I think that's
22 probably the way we need to approach it is -- is determine
23 what the goal is and then just looking at a segment of the
24 health care marketplace to begin with, whether it's -- not to
25 pick on Dr. Urata, but maybe it's the most common procedures

1 of a primary care physician, just get that out first and then
2 go to -- go to -- expand it, you know, identify what's the
3 first stuff we want to get out there, get the bugs worked out
4 of it and then just expand it from there, but I think that's
5 phased approach -- and I don't know -- I wish I could remember
6 who said it, so I can thank them.

7 COMMISSIONER URATA: Didn't Allen say it?

8 MR. PUCKETT: Okay, so a phased approach would probably
9 be the way to go. Thank you.

10 SENATOR COGHILL: Excellent thoughts, it just changed my
11 whole thinking on it. I like the phased approach. So you
12 know, from my neck of the woods, I come from the Fairbanks
13 area and the two issues that drive my economy wild right now
14 are energy costs and health care costs, and the fastest
15 growing segment of our industry is health care costs, mostly
16 behavioral health and elder care are probably the biggest
17 deals .

18 So -- so I'll give you a little context, I was telling
19 earlier, the -- in Fairbanks, we've had many military people
20 come up there, Eielson, Fort Wainwright, love it and retire
21 there and they bring their retirement as a base pay and they
22 work as nurses, retail clerks, they run small businesses and
23 so that is the basis of their staying there.

24 Their quality of life is able to be maintained because of
25 their retirement. When the energy costs and the health care

1 costs get too burdensome, they take their retirement and they
2 go do retail and work somewhere else and then they get twice
3 the value of their dollar and so they're going to Phoenix or
4 places like that and so the crowd-out in the Fairbanks areas
5 is primarily economic, with the idea that they'd like to stay
6 there for the quality of life and so the energy costs are
7 probably the biggest one, but the health care costs are
8 probably right in there with them.

9 So when it comes to price sensitivity, we're probably in
10 the stressed condition, rather than the right to choose,
11 because we're a small market. We are -- we don't have many
12 choices, kind of like Juneau. You have -- you can go to an
13 urgent care clinic or you go to the hospital or you can have
14 your regular doc look at you from time-to-time and then you
15 don't really want to go there because you don't know how much
16 it's going to cost and you don't want to know what you're
17 going to find out sometimes.

18 So you know, that's kind of where most normal people are
19 living. So when it comes to the All-Payers Claim Database, I
20 think it was well said when the industry folks are probably
21 more interested than the consumers until they have a need.
22 That's when they need to know, but price sensitivity, this is
23 where I said yesterday, price and value have -- are a little
24 different because I trust my doctor to tell me where's the
25 best place to go and that's, to me, the value statement.

1 That's not a price sensitivity statement, but if my doc
2 says, "Look, you really need to get this done," and -- I might
3 be able to choose between a \$1,200 and a \$2,500 procedure,
4 maybe, but if the doc says the \$2,500 one is what you need,
5 probably -- so the trust factor is very important.

6 So the Claims Database, probably, is as important to the
7 doc as it is to the consumer because the doc may be able to
8 say, "Yes, here's the price variation and here's the scope,
9 but because of your condition, you need X," and to me, the
10 trust factor on the doctor is very, very high. So if we had,
11 say a scope of practice norms, like what Jim was saying, that
12 probably would be helpful, but for me, as a consumer, I'm not
13 going to check.

14 Then the other thing that I think we need to think about
15 is when you go to a hospital and you're going to get a
16 procedure, you're going there based on your primary doctor,
17 but between the anesthesiologist and what, the five other
18 people that are going to be dealing with you there, the post-
19 op nurse, et cetera, et cetera, those are charges that you
20 never get to discover before the procedure's over and
21 sometimes, you don't even know who they were until the billing
22 and there's a transparency that I don't know how to get to,
23 but I don't know that an All-Payer Claims Database really gets
24 you there.

25 There really, probably from the doctor side needs to be a

1 better description of here's what's coming your way, be
2 prepared for it and -- but at the point of the doctor making a
3 recommendation, what are you going to do, tell the doctor, "I
4 don't trust you," and so the doctor's going to say, "Your
5 insurance covers 80% of this. So your portion is going to be
6 \$18,000." Then my choices will kick in and probably because
7 of the way the costs are coming at us from the higher premium
8 standpoint, that makes sense, but to me, the consumer still
9 depends upon the doctor to tell them and I think there's --
10 they generally will know what the insurance will pay,
11 generally, but the doctor is really, in my view, the place
12 where the need to know really becomes obvious and so my
13 question that was generated yesterday was, the Claims
14 Database, does it help the doctor and the patient get there,
15 because the insurance company has already made a contract.

16 So that's pretty straightforward, but the rest of it is
17 operational that has elements of cost that you may not really
18 understand. Most doctors will, but they're not the
19 economists, unfortunately, but -- but those are the people I'm
20 going to go to, to trust.

21 That's been the case in my own personal life, but I've
22 seen it in many others. The only time I've seen price
23 sensitivity really take in is shoulder operations, maybe major
24 tooth work, things that you might be able to say, "Go to
25 Seattle." You're going to go stay there a week, get a

1 procedure done. You can actually buy a ticket, hotel room,
2 get a big spa, live in real luxury and it's still cheaper than
3 doing it here at home.

4 Then the other thing is, those conditions that just are
5 so dramatic, whether they're cancer, you've got to go to
6 specialty places, at that point, it's catastrophic insurance,
7 probably, and I don't know that price sensitivity is even in
8 the question at that point, you know, you're -- until you get
9 into your insurance end.

10 So I think the scope is a good idea, but I think somehow,
11 the doctors, unfortunately, probably are going to bear it .
12 So how do we draw them into that discussion? Is that a place
13 that -- do I misunderstand that, but I can tell you for me, as
14 a consumer, they're the first person I ask, where is this
15 going? What do you think it will cost, and I don't know that
16 I've gotten good answers to date and maybe the Claims Database
17 helps that. I don't know.

18 REPRESENTATIVE KELLER: If I could just really quickly
19 because it looks like you've been fascinated over the last two
20 days of the very same stuff as I have and it occurred to me as
21 you were talking that there's another element there and I just
22 want to back up on what I said, I think I overstated when I
23 said that Alaskans don't care what the price is and what I
24 meant by that was that they don't care because there's a third
25 payer -- party paying, but there's another element.

1 I was at a meeting last night, and I won't name the
2 candidates or -- you can find that out for yourself, but they
3 -- but the statement was made, we've got to repeal ObamaCare
4 and we have to stop this huge increase in the health care and
5 it was a standing ovation, almost.

6 I mean, what I'm saying is there's an element of the
7 Alaskan citizenry that is very painfully -- they feel the pain
8 of the increasing costs and they care very much. So an All-
9 Payer Claims Database, it would put the information online,
10 even though it wouldn't be a direct use and there may be 17%
11 that refer to it and I think, in general, I think that it
12 would be bigger than that eventually and there's just a
13 growing interest in why it costs 10 times more to get
14 something done here than it does over here.

15 I think more and more of that is becoming street
16 knowledge. People know that, you know, and so I think there's
17 a hunger for the information, but -- so I just wanted to say
18 that I probably overstated that a little bit and I wanted to
19 clarify.

20 COMMISSIONER DAVIS: Thank you for the time to reflect.
21 So trying to sort this out, so why are we having this
22 discussion? We're having the discussion because we have a
23 problem. We are spending and we've heard anecdotal evidence
24 of that problem that we're spending more on health care every
25 year at an unsustainable rate and if you run that curve out at

1 15%, eventually, we're spending 100% of GDP on health care and
2 that, clearly, is not sustainable and maybe 21% isn't.

3 I don't know, but that's why we're having the discussion
4 and the premise of the discussion, I think, the underlying
5 assumption is that there's waste that is occurring and we've
6 heard conversations about that 30 to 40%, depending on the
7 study, if every dollar that's spent in health care is waste,
8 to find something that doesn't help, and in fact, may hurt and
9 do that's, as Dr. Hurlburt pointed out yesterday, doing the
10 quick math, that's a trillion dollars and that's a lot of
11 money, if you just look at the portion in Alaska.

12 So that, to me, is the target. That's the bogey and one
13 of the ways, one of the forms waste takes is price
14 inefficiency, so a price that's extraordinarily high compared
15 to a market rate and I know, Allen, we've talked about price
16 and cost and it's really hard to get to, but the example I
17 used yesterday is my wife's seeking care and getting it from
18 one provider and then switching Dr. Stinson in the same care,
19 actually higher quality because he's the one who taught the
20 other group how to do this procedure, at one fifth the price.

21 So that \$20,000 that was wasted each time Suzanne went to
22 them, that was waste in the system and if the physician she
23 had been working with prior to going there had known that and
24 been able to say, "Well, this is higher quality or these are
25 equal and this one costs five times as much as this one,"

1 well, of course we're going to go here, but nobody knew that.
2 I didn't know that until after the fact when I'd seen bills
3 from one and bills from the other.

4 So there's an opportunity, and I think often times, the
5 opportunity is at the physician who's doing the referral and
6 Dr. -- when Noah was on this -- Dr. Laufer was on the
7 Commission, he often stated that he didn't know. He didn't
8 know if someone needed a shoulder, who charged 100,000 and who
9 charged 50 and if he knew it, then he would make a judgment
10 about quality and price is, in fact, a part of quality because
11 it's a part of waste.

12 So we need to somehow get to this, but as we've said over
13 and over, it's really complicated. So there are people who
14 spend their lives, their professional lives figuring this out.
15 They're actuaries, usually, and health care economists and
16 Aetna's got an army of them and Cigna's got an army of them
17 and Humana's got an army of them and United's got an army of
18 them and Premera's got an army of them.

19 We've been working this out and every time our Aetna
20 friends or Blue Cross friends go for a piece of business,
21 that's one of the top things that gets discussed is consumer
22 tools, is what it's called, and so a lot of progress has been
23 made in the private sector in trying to get to price
24 transparency.

25 In Premera's case, it's on a cost per case basis and even

1 if you go to some place like Seattle and you say, "How much is
2 a total hip at Virginia Mason or Swedish or Overlake or
3 Evergreen," there's tremendous variation just between those.
4 Well, those are all fine institutions. So if you know that
5 it's twice as much one place as it is another, you know that
6 in advance, it's elective. It's planned. You can make
7 decisions based on that.

8 So the thought I had is that it would be impossible for
9 us to say, "This is the solution. This is what it should look
10 like." We can't do that. We could lay out principles, like
11 we suggested yesterday, like are laid out in the HFMA paper
12 and then -- but then it's going to take an Army of actuaries
13 and experts to really figure out what that looks like and one
14 thought I had, and this may be pie-in-the-sky dreaming, is the
15 people who are covered by Aetna have access to their tools.

16 The people who are covered by Premera have access to
17 their tools. It's the people who aren't covered by a major
18 carrier that has tools that don't have it. Well, what if we
19 asked Aetna and we asked Premera to make their tools available
20 to people who weren't their customers? I mean, they might
21 say, "No." They might say, "You're crazy," but why would we
22 replicate the work that's already been done and is going to
23 continue to be done and continue to evolve.

24 So that's my crazy thought for the morning. I don't know
25 if it will go anywhere. Probably if Premera people are

1 listening, they're ready to kill me right now, but they only
2 have a few more days. So what are they going to do, fire me?
3 So I hope that makes some sense, but that's the way it kind of
4 sorts out for me. So maybe that's not the way to go. Maybe
5 again, that is just ludicrous, but somewhere above that where
6 -- the principles, there's got to be work by people who
7 understand all of the complexity of this because I don't. No
8 one at this table does. No one in this room does. No one
9 actuary does. I mean, it's -- this has been in process for
10 years and years and years with really, really smart people and
11 they're making progress, but I think that's enough. Thank
12 you.

13 MS. ERICKSON: Thank you all very much. I want to check
14 to see if we can hear Dr. Grundy. We're going to have to
15 start our fraud discussion at this point. So I want to see if
16 we can hear Dr. Grundy. Apparently, he's been able to hear
17 us. So Dr. Grundy, if you are on the line -- are -- are you
18 there?

19 DR. GRUNDY: Good morning, I am. Can you hear me?

20 MS. ERICKSON: Wonderful, yay, yes, thank you very much
21 for joining us and thank you for your patience and waiting.
22 So we're about half an hour behind schedule now and is your
23 time okay for you? You're on the east coast. Is it about
24 1:00 there?

25 DR. GRUNDY: Yeah (affirmative). No, it's perfectly

1 fine. Is my volume too high?

2 MS. ERICKSON: You're perfect. We hear you loud and
3 clear.

4 DR. GRUNDY: Okay.

5 MS. ERICKSON: If you can wait just a minute, why don't
6 we just remind folks around the table here and in the room
7 what we're doing. So we just spent what turned out to be the
8 first hour just going around the table and capturing
9 everyone's major take-away thoughts from yesterday's
10 conversations and we're shifting from the employer's role and
11 health and health care and the conversation around
12 transparency to the conversation this morning about fraud.

13 We had a presentation on fraud control in Alaska's
14 Medicaid program by Andrew and Doug at our last meeting in
15 March. I have provided for the Commission, you all received
16 in your notebooks when you got them a week or two ago, the
17 notes from that meeting and I also gave you just a one-pager
18 this morning with what were your very early preliminary
19 thoughts after the Medicaid fraud control and Medicaid program
20 integrity.....

21 UNIDENTIFIED SPEAKER: You cut out.

22 MS. ERICKSON: So did Dr. Grundy not hear me?

23 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
24 microphone) everybody else (indiscernible - too far from
25 microphone).

1 MS. ERICKSON: Do you think -- okay, sorry for the
2 continuing technical problems and so anyway, that -- your very
3 preliminary thoughts after those presentations on what you
4 thought the major finding points and also thoughts about
5 potential recommendations might be and we've invited, not only
6 Doug and Andrew back to have a conversation with you all about
7 ideas for improving streamlining and strengthening Medicaid
8 fraud control activities, we've also asked Margaret Brodie,
9 the Director of the Division of Health Care Services to talk
10 with us about medical claims management and when we get to
11 that point, Dr. Hurlburt will introduce her a little bit more.

12 We also asked the -- initially the Department of
13 Administration, the Health Plan Administrators for help with -
14 - to help us understand how more on the private sector side,
15 but state government specifically on the employee insurance
16 side, what might be going on there related to fraud control
17 and also medical claims management. We're going to actually
18 put Dr. Bartholomew a little bit on the spot. We just asked
19 her yesterday or the day before to help with that piece.

20 So that's why Dr. Grundy's on the phone this morning. He
21 is with the -- is the Medical Director for the Special
22 Investigations Unit for corporate Aetna nationwide and he's
23 on the phone with us this morning from Connecticut and Ward,
24 do you have anything else by way of introduction? So now, we
25 might need to take a short break here to figure out our

1 technical problems. Okay, Dr. Grundy, you're on the line?

2 DR. GRUNDY: Yes, I am.

3 MS. ERICKSON: Very good. I will stop talking now and
4 turn it over -- and if it really is my microphone, Ward, maybe
5 you can do the introductions and lead the conversation for the
6 rest of the fraud discussion, at least while Dr. Grundy's on
7 the phone.

8 CHAIR HURLBURT: Dr. Grundy, welcome and this is Ward
9 Hurlburt. I'm chairing the Commission, but I think we're all
10 set.

11 DR. GRUNDY: Good morning.

12 CHAIR HURLBURT: You could go ahead, please.

13 DR. GRUNDY: Good morning to the entire Commission. It's
14 a pleasure for me to have an opportunity to briefly discuss
15 with you fraud and abuse activities from the point of view,
16 from the perspective of a payer, such as Aetna.

17 By way of personal, professional introduction, let me
18 just say briefly that I have been in the field of medicine for
19 almost 40 years now. After my residency training ages ago, I
20 was a primary care pediatrician for 21 years in a large group
21 practice. I then changed careers, if you will, and have been
22 involved in health plan work for the past 18 years.

23 I've been with Aetna for the past 15 years, of which the
24 last six years have been with the Special Investigations Unit.
25 My plan is to speak to the content of the SlideDeck for maybe

1 15 or 20 minutes, if that's acceptable, and then entertain any
2 questions that you might have about the material I present or
3 other things that may be of interest to you.

4 If we could proceed to the second slide, excellent, this
5 slide includes information about the mission and purpose of
6 Aetna's SIU, as well as a summary of our major activities.
7 The mission and purpose includes three elements that you can
8 see here on the slides.

9 The first sort of emphasizes the, almost obligatory,
10 commitment to detecting, investigating, recovering and
11 preventing fraud and abuse. The second element reflects our
12 commitment to compliance with state and federal regulations,
13 particularly in our Medicaid and Medicare fraud activities and
14 then finally, the final element is that we do have a fiduciary
15 responsibility to our members and our customers to ensure that
16 health care dollars are being spent appropriately.

17 We strive to be one of the industry leading SIU's and
18 feel that we're at least up there at the top. The graphic
19 wheel depiction there of our major activities has the five
20 components that you can see with definitions to the right that
21 I think you're probably familiar with by now through previous
22 discussions that you've had.

23 The only point I will make -- a couple of points I will
24 make about this part of the slide, virtually always the
25 detection preceding to the investigation components are

1 present in virtually all of the cases that we're involved in.
2 The remaining steps, the recovery, the reporting, the
3 prevention, may or may not occur and they're sort of
4 contingent on the results of the detection and investigation
5 activities.

6 I would also emphasize that in the process of all of
7 this, we have a very close working relationships with state
8 and federal agencies, including CMS, the OIG, state Medicaid
9 fraud units and various law enforcement organizations, as
10 well.

11 Next slide, please. This is a summary of how we go about
12 our fraud and abuse work. This is the job descriptions, if
13 you will, of the total staff of 131 individuals that we have
14 on our team, in our business unit. It's a large staff,
15 comparatively, I believe to other payers. These individuals
16 are divided into or allocated into four functional areas.

17 We have a commercial investigations area that's located
18 here in the home office at Hartford. It has two provider
19 teams, one for the west, one for the east and a member/forgery
20 team. A second functional area has to do with government
21 investigations and pharmacy and as you can imagine, it
22 includes our Medicaid team, our Medicare team, a prepayment
23 team involved with government programs and pharmacy.

24 A third area is several teams that comprise our field
25 unit. There are four teams and they're predominantly the

1 investigative analysts that you see on this slide. They are
2 mostly responsible for administering our flagging program or
3 the program involved in prepayment review and I would say that
4 they're all in the field, as it suggests on the slide, in
5 different locations across the country and I would say
6 probably about a third of the total staff falls into these
7 field analysts and then finally, we have a systems and
8 reporting functional area and that's where the data mining
9 takes place.

10 It's where a triage of cases that are brought to our
11 attention takes place. It's also where the reporting occurs.
12 This staff is comprised of a mixture of clinical and
13 nonclinical individuals, many of them are certified coders and
14 those that are not, are encouraged to become so and we are --
15 we're proud of the individuals that staff this organization.

16 We can go to the fourth slide. This presents sort of a
17 breakdown, a pie chart, if you will, of current relative
18 frequencies of provider schemes that we encounter. I'd like
19 to highlight two segments on this graph. The first, the
20 largest one, 2/3 of the provider work you see is in the area
21 of creative coding and misrepresentation and I'm assuming the
22 audience has -- is familiar with the coding process that
23 providers have to go through to seek reimbursement and issues
24 in coding have to do with using the wrong codes for the wrong
25 services, up-coding, coding for services that are more complex

1 and reimburse at higher rates than what was really performed,
2 misrepresentation, as you -- as the name implies is using --
3 saying -- billing for one service, coding for one service
4 when, in fact, something else usually associated with lower
5 reimbursement occurs.

6 This is the part of the SIU where I spend most of my
7 time, because this usually requires a medical record review at
8 some point and that's the predominant role of the medical
9 director in our organization. I spend a lot of time here and
10 a lot of time also in our data mining efforts.

11 The other segment that I would point out about 20% is
12 identified there as illegitimate or phantom providers and this
13 is a fascinating area nationally, anyway. It involves
14 situations where we are billed by -- through Post Office Boxes
15 by providers that really don't exist for services that weren't
16 rendered or storefronts where minimal services are rendered.

17 At times, this is related -- has in the past been related
18 to organized crime. It involves, often times, stolen
19 identities of members. It's often times a very quick hitting
20 scheme in the sense that by the time a health plan realizes
21 what's happening, the guilty parties have often times stopped
22 what they're doing or, at least, they've received the money
23 and money is often times out of the country by the time we
24 know what's happened.

25 This has not been quite as common recently. It does have

1 -- it does -- it has seemed to have a geographic predilection,
2 in our experience, predominantly in Florida and the
3 metropolitan New York area and some other urban sites as well.

4 The final comments I would make about this slide, going
5 back to the creative coding and misrepresentation, is that a
6 lot of this work also has to do with our determination of
7 whether services that were rendered were medically necessary
8 or were they, in fact, experimental and investigational and we
9 have a separate business unit within Aetna dealing with
10 medical policy that creates what we refer to as clinical
11 policy bulletins or CPD's and those documents are essentially
12 a summary of a particular procedure or service with respect to
13 the evidence in the peer review literature.

14 So the folks in the medical policy section now are
15 maintaining a library, if you will, of almost 900 of these
16 CPB's and they refresh them annually with updates of the
17 literature and we have been able to use, successfully use
18 these clinical policy bulletins as an authoritative basis for
19 us disallowing some services as being experimental or
20 investigational.

21 If we could go to slide five, okay. This is a list of
22 how we learn about cases, the different source that will make
23 us aware of potential cases of fraud and abuse. One major
24 take-away from this is we try to -- by this slide, we're
25 trying to emphasize the multiplicity of the sources that we

1 rely on.

2 I don't have an actual percentage breakdown of, you know,
3 what percent we got from which of these bullet points, but I
4 do have a couple of comments to make about this because I
5 think it's particularly important for a market or a customer,
6 such as the state of Alaska, to understand.

7 The data mining that we do, and it's predominantly
8 through this fraud and abuse management system call FAMS, that
9 we've been using now for probably, at least, a decade or more.
10 It's a product -- it's an IBM product and we use this to -- to
11 mine our database and look for outliers for billing certain
12 services and procedures and as I mentioned earlier, I spend a
13 lot of time in this activity.

14 Almost by definition though, data mining requires a large
15 provider claim volume and a high membership in a particular
16 region. We look for outliers on a regional basis, but the
17 results we get from the data mining are predominantly in the
18 larger markets. So to counterbalance that and to enable
19 customers in the smaller markets to, and members in smaller
20 markets, to have access to us and to bring suspicions of fraud
21 and abuse to our attention, we -- it's important that those
22 markets and plan sponsors be aware of the telephone hotline
23 that's on here and the service email.

24 Now for some reason, this slide doesn't have the hotline
25 number or the email address. I can tell you both of them.

1 The telephone hotline is a 1-800 number, 338-6361, 338-6361
2 and the e-referral address is aetnasiu@aetna.com. Now, the
3 telephone hotline messages are retrieved every day, Monday
4 through Friday. The -- and in a similar fashion, the e-
5 referrals are monitored continuously and all of them are
6 addressed and it's important to understand that, too, because
7 as many of you probably know, in this work of fraud and abuse,
8 there are certain -- when we're investigating and pursuing
9 cases, there are certain constraints in what we can share with
10 others, constraints related to HIPAA, constraints related to
11 legal circumstances.

12 So it's important to know that, although we may not be
13 able to share with a whistle-blower or someone who has brought
14 something to our attention the details and/or the results of
15 our investigation, we want to assure people that every single
16 thing that comes into the hotline or the e-referral mode is
17 investigated.

18 Now what we do for employers, plan sponsors, and I think
19 it's predominantly the self-insured ones, but people who are
20 concerned that their money -- who have -- who have been
21 looking at how their money is being spent and are concerned
22 about a particular provider or diagnosis or something, we do
23 get back to employers in those situations to share with them
24 what we can.

25 So again, the point of this -- the main take-away from

1 this slide is that while the data mining may not dig in as
2 deep as one would want, maybe, in the smaller markets, there
3 are other means that we learn of cases and we encourage
4 multiple sources and finally, on the last slide, slide six, I
5 tried to come up with some metrics that might be of interest
6 to the commission for our last complete year of business,
7 2013.

8 The metrics in fraud and abuse are not quite the same as
9 one might encounter in other areas of health care management.
10 You know, we don't have unit cost statistics. We don't have
11 utilization statistics, but we do have some numbers. For
12 2013, our total savings and recoveries, this slide says 300
13 million. Actually, the final figure was 349 million and we're
14 particularly pleased with that because it's double what our
15 savings and recoveries were as recently as 2008, six years
16 ago.

17 Now this is due predominantly to an increase in staffing
18 and increase in efficiencies in how we do our work. It almost
19 certainly is not due to the fact that's when I joined the
20 company, the SIU, but maybe a bit because the staffing did
21 increase significantly at that time.

22 It looks like a lot of money and it is. I should tell
23 you that about 98% of this 349 million represents savings,
24 sort of claims that were disallowed before money went out the
25 door. Recovery's only about 2% and there's a couple of

1 reasons for the recovery at 2%. One is they're very difficult
2 to do. They're time-consuming. They're resource intensive
3 and one has to make some judgments about what one chooses to
4 pursue and so -- and also, while the 349 million sounds quite
5 large, it's actually less than 1% of the total \$47 billion in
6 revenue that Aetna was involved in, in 2013. So we know
7 there's a lot of fraud and abuse out there that we still need
8 to identify and pursue.

9 A couple of other statistics before I close, on an annual
10 basis in -- well, at least for the year of 2013, and this is
11 about through now, we get about 150 new cases from all those
12 sources I mentioned per month, a total of 1,800 for the year.
13 At any point in the year during 2013, we had 25,000 cases that
14 were open and being pursued, either through investigations and
15 recoveries or through prepayment review.

16 I did some digging to find out about our specific
17 experience in Alaska in 2013. There -- and I don't know any
18 details of these, which means that they did not involve
19 medical record review, but there were five cases, three of
20 them involving providers and two involving members.

21 You know, I -- we show that slide of the provider
22 schemes. The most predominant member issues that we deal with
23 have to do with inappropriate member reimbursements, members
24 who are seeking -- who allegedly have paid their provider and
25 are seeking personal reimbursement from Aetna.

1 For 2014, we currently have one provider and one member
2 case open and again, I don't have the details of that --
3 those, but again, it's -- that's mostly because these -- these
4 did not involve a medical record review.

5 I believe I'll stop at this point, if that's okay and
6 entertain any questions, if the sound system allows that.
7 Hopefully, the audience was able to hear most of what I had to
8 say.

9 CHAIR HURLBURT: Dr. Grundy, this is Ward Hurlburt. I'm
10 also a physician here Chairing this and I'll start out.
11 First, can you hear me okay?

12 DR. GRUNDY: Yes, I can, Ward, thank you.

13 CHAIR HURLBURT: Sure, and you came across very, very
14 clearly and the slides were helpful and we really appreciated
15 that. I'll start out with a couple of questions and this
16 relates to your last slide, the top bullet there, where your
17 savings and recoveries were about \$350 million.

18 There has been a lot in the media lately about CMS
19 efforts, Medicare efforts specifically, related to fraud and
20 abuse and various percentages tossed out of what the likely
21 potential is there. In our discussions, we basically felt
22 that it's a very small proportion of providers who are bad
23 apples, but that they need to be vigorously weeded out and not
24 tolerated, but because there is so much money in health care,
25 that even a very small proportion adds up to significant

1 dollars.

2 So my question -- I would have two questions; one is do
3 you have in your own mind an estimate of what the likely
4 potential is for Aetna there, compared to the less than 1% of
5 recoveries now from the total gross income of the company, and
6 2) as a private entity, what is your sense of how successful
7 you are able to be in pursuing fraud and abuse compared with
8 what Medicare is able to do?

9 DR. GRUNDY: Right. Well, I -- I agree with your initial
10 comment that as far as professional health care providers,
11 it's a very small percentage of the bad apples, as you say,
12 but it's important to realize, too, and this is especially
13 true in the government programs, that a lot of the offenders
14 are not clinical providers.

15 A lot of the offenders end up being non-clinical folks
16 who are sort of entrepreneurs and have opened up, you know,
17 some of these storefront sort of things or they're running
18 some sort of fad clinics or whatever, but it's remarkable to
19 me what a large percentage of non-professional individuals are
20 involved in fraud and abuse and I think the government
21 programs and especially large CMS fee-for-service experiences
22 that a lot.

23 To your question about the potential to do better here, I
24 -- you know, we are constantly, and this is from Aetna's
25 perspective, looking for better ways to mine data and to put

1 appropriate filters on and to triage the cases that rise to
2 the top, because one has to appreciate the fact that not all
3 outliers, not all high utilizers are committing fraud and
4 abuse and so, at an early stage of our detection process, we
5 try to eliminate those where there's a plausible, logical
6 reason why a particular physician would be billing certain
7 codes frequently.

8 To the degree we can get better at that and not have to
9 spend our time on cases that don't pan out, we're confident
10 and we set our annual goals to increase our recoveries or
11 savings each year. So already, for 2014, while I can't share
12 the internal goal that's been set, I can tell you that it's
13 comparable to, if not more than the 349 million. I hope that
14 answers at least part of what you were asking.

15 CHAIR HURLBURT: Well, yeah (affirmative), and then the
16 second question was just your sense, as a private company, how
17 successful you can be, maybe, compared to Medicare, as a
18 benchmark, in other words, are you really able to do this much
19 more efficiently or does the potential cloud of FBI agents
20 with drawn pistols not enable you to do as well as Medicare?

21 DR. GRUNDY: Right, well, certainly, the federal
22 government has some advantages when they're pursuing this that
23 we don't. I mean -- I mean, they imprison people and there's
24 always that threat hanging over the head of guilty offenders.

25 I will say this, though, there is another factor for us

1 that I think makes us possibly more effective than some of our
2 peers in the payer community is that we -- we have a very
3 aggressive approach to fraud and abuse and it's partly due to
4 the staffing that we have, but it's also due to our
5 leadership.

6 Our current Director comes out of law enforcement, state
7 police. His predecessor was also law enforcement, state
8 police and so we are -- not only do we not tolerate fraud and
9 abuse, you know, regardless of who's doing it and what size,
10 the amount of money involved, we also are very aggressive
11 about pursuing it in our discussions with providers and we
12 know in some markets that our activities, as assertive as they
13 are, do tend to have a sentinel effect among providers in a
14 community where when the word gets out that we have, you know,
15 come down pretty hard on somebody, that, you know, that gets
16 out in the community and we're hoping, although, there's not a
17 way really to measure it, we're hoping that helps reduce the
18 frequency of fraud and abuse, as well.

19 CHAIR HURLBURT: Thank you. Are there some other
20 questions here? Yes, Allen, and maybe if you can identify
21 yourself for Dr. Grundy?

22 COMMISSIONER HIPPLER: Dr. Grundy, this is Allen Hippler.
23 I'm a member of the Commission. Thank you for talking to us
24 today, sir. Are you there?

25 DR. GRUNDY: Good morning, thank you.

1 COMMISSIONER HIPPLER: So talking about Medicaid and
2 Medicare, some of the fraud that I've seen recently involves
3 medical care providers, essentially convincing themselves that
4 even though they're acting illegally, they're acting morally.
5 They're doing the right thing by double-billing Medicare or
6 Medicaid so that they can cover their costs so that they can
7 treat people who need health care and so they're able to
8 convince themselves that they're doing the right thing, which
9 essentially makes them even harder to catch because, you know,
10 they're not guilty. They don't feel guilty. Are you seeing
11 any of this in the private sector at Aetna?

12 DR. GRUNDY: Well, we certainly see a wide variety of
13 rationalizations for what providers will use as an explanation
14 of their activity. I don't know that I've specifically seen,
15 as much of what you -- specifically you described, but as I
16 said, there are all kinds of explanations that we do encounter
17 and we -- one of the more frustrating ones is that physicians,
18 often times, in good faith feel that a particular service or
19 procedure that they're delivering is medically necessary and
20 the right thing to do and yet, it's not supported in the
21 medical literature or at least in the peer review literature
22 and so we often times have difficulty dealing with some
23 providers who are insistent that what they're doing is
24 medically necessary and effective when, in fact, the
25 literature doesn't show that and we always have to retain a

1 little humility about this because over years, we will see
2 sometimes in our own clinical policy bulletins, we'll see our
3 position change on a particular therapy as more literature
4 comes out and supports the efficacy of it, but I would say one
5 of our biggest challenges, though, is dealing with resistance
6 of providers, whether they're just, you know, venting or
7 refusing to send us records or whether when we catch them at
8 something, their ingenuity in coming up with a rationale for
9 why they did something.

10 CHAIR HURLBURT: Thank you. Other questions for Dr.
11 Grundy?

12 COMMISSIONER DAVIS: Dr. Grundy, this is Jeff Davis, also
13 a member of the Commission. I'm just interested in your -- a
14 little bit of an elaboration on the current schemes slide, the
15 box that talks about forgiveness of coinsurance and/or out-of-
16 network penalty. I'd just like to hear your -- a little more
17 color commentary on that, please.

18 DR. GRUNDY: Yeah (affirmative). Did you have a
19 particular question about it or.....

20 COMMISSIONER DAVIS: Just, I think it would be useful for
21 you to talk about that, I mean, it's a fairly large chunk of
22 the total, almost 9% and how you're seeing that manifest
23 itself. It could be educational for the Commission.

24 DR. GRUNDY: I didn't hear all of the question, but I
25 think you were talking about the 9% of coinsurance.....

1 COMMISSIONER DAVIS: The 8.9%.

2 DR. GRUNDY:or out-of-network penalty, was that it?

3 COMMISSIONER DAVIS: Yes, if you could comment more on
4 that, that would be great.

5 DR. GRUNDY: Yeah (affirmative). Well, unfortunately,
6 I'm not sure how much I can add to this, in part because the
7 folks who deal with this within the unit are not in the areas
8 where I am most active.

9 I can say, though, that these kinds of cases, when we
10 ask, well, what are the sources of this kind of thing, these
11 are the kinds of things that come to us, not through data
12 mining, but through a whole host of, you know, folks that I
13 call whistle-blowers, but they're really people who are
14 troubled by what they're seeing and they notify us about it.

15 So it could be -- it could be a relative of somebody. It
16 could be a disgruntled employee of a particular provider and
17 once we learn of this behavior, then we have mechanisms
18 internally, and again, I don't work with those folks, to
19 pursue this and it's -- actually from my practice experience
20 ages ago, the, you know, the inclination to do some of this,
21 to forgive a member certain out-of-pocket expenses is tempting
22 and until you realize that it's not legal, but it's tempting
23 to do this, but we learn about this through those alternative
24 sources, rather than the data mining.

25 I wish I could elaborate a little bit more on the work

1 flows that are involved, but I'm not sure how stimulating that
2 would be, but there are processes in place to address this and
3 as you can see, it's a 9% figure. So it's not insignificant.

4 COMMISSIONER DAVIS: Thank you very much. I appreciate
5 that. I have been aware of circumstances where this was
6 fairly broadly spread in Alaska, so it's good for us to
7 understand that. In fact, it is illegal and even though the
8 motivations behind it may be moral, you know, that it is, in
9 fact, illegal. So thank you.

10 DR. GRUNDY: Yeah (affirmative), and from an economic
11 point of view, I mean, it defeats the purpose of many, you
12 know, plan designs and it just make the provider who's
13 forgiving it here, you know, want to make it up somewhere
14 else, but I think the other important thing is that it's
15 important to understand that if somebody is aware of this kind
16 of behavior, specific instances, and wonders if this is
17 something that's legitimate to report, it certainly is.

18 CHAIR HURLBURT: Thank you, Dr. Grundy. Jeff, did you
19 have another comment? I think we'll have time for one more
20 question. David.

21 COMMISSIONER MORGAN: This is Dave Morgan. I guess my
22 question is, when we had our discussion in Juneau, it sounded
23 like our main two areas that we were, at that time, bouncing
24 around with what I call real fraud, you know, there's -- I'm
25 out of the industry. There's fraud and then there's just

1 abuse, you know, and fraud, it was basically -- it was not
2 providers. It was what you said.

3 DR. GRUNDY: Unfortunately, I'm not picking up the volume
4 on that, of.....

5 COMMISSIONER MORGAN: Okay, can you hear me now?

6 DR. GRUNDY:the question. Could it be repeated?

7 COMMISSIONER MORGAN: Yes.

8 DR. GRUNDY: Dr. Hurlburt, I'm hearing you pretty well.
9 Could you repeat the question?

10 COMMISSIONER MORGAN: Yeah (affirmative). Yeah
11 (affirmative), I was looking down when I should have been
12 looking forward into the mic. We found.....

13 DR. GRUNDY: Well, I hear you fine now.

14 COMMISSIONER MORGAN: Yeah (affirmative). Yeah
15 (affirmative), I got it. Anyway, in Juneau, at our last
16 meeting, we had a discussion on this and the primary areas
17 which may have changed, I don't know, was non-providers. It
18 was -- it was care being delivered at home and it was.....

19 DR. GRUNDY: Right.

20 COMMISSIONER MORGAN:transportation and I thought
21 it was very inventive that our fraud guys here were, at
22 Medicaid, were working with ICE to track down people that were
23 signing for things, but at the same time, were like in
24 Lithuania or somewhere, which.....

25 DR. GRUNDY: Right, right.

1 COMMISSIONER MORGAN:I found pretty interesting.

2 DR. GRUNDY: Yeah (affirmative), I think if one -- if one
3 has occasion to read through records of fraud cases that have
4 been closed, I mean, just sort -- it's remarkable how many --
5 how prevalent the area of home health care and what have you
6 has increased, at least from my perspective, in recent years
7 and often times, the offenders are not actually clinicians.

8 COMMISSIONER MORGAN: Okay, and the second thing was --
9 it was -- I was back home or visiting family and there was a
10 major case broke where there was a large number of fraudulent
11 billings for dead MD's, and you know, I was wondering if -- is
12 -- are you seeing that, too, where a provider has passed away
13 and bills keep coming? Has that -- or is that pretty well
14 just was one of those odd ball things that happened?

15 DR. GRUNDY: I'm not familiar with it being all that
16 frequent. The more frequent problem is not so much a -- I
17 mean, there's certainly activity -- fraudulent activity that
18 we're familiar with and have to deal with, with deceased
19 members who are still being billed. A deceased physician is a
20 little bit different.

21 On the physician side, our bigger problems are physicians
22 who are not -- who don't have a valid license. You can see
23 it's a small percentage on the pie chart there. It's one
24 percent, but that, we do see.

25 CHAIR HURLBURT: Okay, Dr. Grundy, we so much appreciate

1 your sharing with us and being generous with your time. This
2 has been very interesting and very enlightening and
3 insightful.

4 DR. GRUNDY: Well, I hope it's been informative and it's
5 a pleasure speaking with you and I'm sorry I'm not able to
6 stay on longer, but I wish you well for the rest of the day.

7 CHAIR HURLBURT: Thank you and we wish we could have
8 gotten you up here, maybe with a fishing pole, as well, but
9 thank you, sir, and have a good rest of your day.

10 DR. GRUNDY: Yeah (affirmative), I've never been and I --
11 and I regret I wasn't able to make the trip, but I've heard
12 great things.

13 CHAIR HURLBURT: Thank you, bye now.

14 DR. GRUNDY: Thank you, bye, bye.

15 CHAIR HURLBURT: So we'll move right onto the next
16 session and Doug Jones, who is with -- the Medicaid Program
17 Integrity Manager here will be here and Andrew Peterson, the
18 Assistant Attorney General with the Medical Fraud Control Unit
19 and for both of you, gentlemen, you just impressed us so much
20 last time that we absolutely had to have you come back for an
21 encore, but what I understand, you have some comments, no
22 formal slides this time, but some comments and then we'll have
23 a discussion among the group for this next session. So if you
24 both could come up to the table here, I'd appreciate it, and
25 again, welcome and thanks so much for coming.

1 MR. JONES: Thanks for having us back. I'm actually kind
2 of surprised. I do see that, though there's been some lessons
3 learned from last time and that you have us here in the
4 morning, rather than the afternoon, because talking about
5 audits in the afternoon can get to be a daunting task. So
6 thanks for having us back.

7 MR. PETERSON: Yeah (affirmative), I appreciate it and I
8 don't know if -- do you want to go first or?

9 MR. JONES: I'm sorry, I am Doug Jones. I'm the Manager
10 of the Medicaid Program Integrity Section for the state. I've
11 been doing -- I've been in this current role for about five,
12 six years, have a long sort of history of audit experience
13 within the health care world. I started probably in 1992 with
14 the then Medicaid Rate Advisory Commission doing --
15 establishing rates for hospitals and nursing homes, doing
16 audits of Medicare cost reports and that sort of thing and
17 have been in various roles with the Department of Health and
18 Social Services between 1992 and today, so.....

19 MR. PETERSON: My name's Andrew Peterson and I'm with the
20 Medicaid Fraud Control Unit and I'm Assistant Attorney General
21 for the Department of Law and I've been with the Department of
22 Law 10 years and in my current role just for a couple of years
23 with the Medicaid Fraud Unit. No worries.

24 MR. JONES: So yeah (affirmative), I'd be happy to lead
25 off. So you know, I've been asked to prepare some comments,

1 just relating to sort of how do -- how to strengthen and/or
2 streamline, you know, the audit process within Alaska. Since
3 our last, the last presentation, last meeting we had, there
4 have been some kinds of interesting developments in the audit
5 world, I guess, primarily surrounding the -- our RAC
6 contractor and you might have -- you might recall that our RAC
7 contractor is a recovery audit contractor that is required
8 from -- through the Affordable Care Act.

9 It rolled out the RAC process from Medicare, where it
10 apparently had great success, although, depending on who you
11 talk to, that's not at all correct, so it's rolled out between
12 Medicare and required all Medicaid programs to establish a
13 RAC.

14 Our RAC contractor in the -- in the two years we've been
15 contracted with them, HMS, is basically losing money up here.
16 They are not -- they've recovered somewhere on the order of
17 half a million dollars for us and are really not particularly
18 interested in continuing in this contractual relationship with
19 the state of Alaska.

20 So that is kind of an interesting development. I mean,
21 that was one of the, sort of one of the primary, you know,
22 areas of audits, I guess. You know, the -- when you talk
23 about audits in the state of Alaska, you really talk about the
24 audits under state statute 4705.200 and then you talk about
25 sort of the new stuff that's come along and one of the -- one

1 of the biggest new things that has come along since then is
2 this recovery audit contractor, where they receive a
3 percentage of the recovery and that's required through the
4 federal law, the Affordable Care Act and it's how that was set
5 up, is that our current audit program that we had with --
6 under our state statute wasn't -- didn't qualify as a RAC
7 because it was not paid on a contingency fee basis.

8 So that's something we're currently sort of working with.
9 We don't know where this is going to go. Eventually, we're
10 sort of in negotiations now with both the contractor and with
11 CMS. There is the potential that we could request an
12 exemption from CMS. I'm aware of, I think, two states that
13 have had an exemption from the RAC in total.

14 I know Vermont, I think, currently has one and I think
15 South Dakota had one for a while, but I'm not sure that it's -
16 - that CMS has allowed them to continue. So that's one
17 possibility that's something that, you know, we're thinking
18 about and working with both CMS and our contractor on. So I
19 wanted to bring that to everyone's attention.

20 As far as -- as far as strengthening the, you know, the
21 program, I think there is several ideas. A couple that we
22 have discussed is the enrollment of rendering providers, so
23 enrolling, and this is akin to the PCA world. So several
24 years ago, we undertook an effort to enroll all of the
25 personal care assistants within the state and do -- and once

1 we had them enrolled, we were able to do the data mining and
2 see some of the, you know, some of the interesting statistics
3 that come out from having that data in front of you.

4 So we do not have that data for many of our home and
5 community-based waiver providers, which are a very similar
6 provider type in that they're doing chore and respite and
7 doing some of those in-home services that are very similar to
8 a PCA.

9 So by virtue of having them enrolled, we would then get
10 additional data that we -- that would just, you know, in the
11 world of PCA, it's made a huge difference in being able to
12 identify fraud, waste and abuse within that program. So
13 that's one area, the home and community-based waiver
14 providers, enrolling them, as well as the behavioral health
15 providers.

16 So there's an additional population of providers out
17 there doing largely home services under our behavioral health
18 programs and the enrollment of those providers would also be a
19 huge benefit and being able to see into, you know, just using
20 claims data, see into what appears to be fraud, waste and
21 abuse and then we can follow up on it from there.

22 So there's -- that was sort of the, you know, one of the
23 biggest areas I think we could improve on and really get a lot
24 of mileage, I think, out of, you know, out of that effort.

25 Another thought that we had discussed was the targeting

1 of provider types within the state statutes. So the statutory
2 audits that are done under AS 4705.200, we tend to call them
3 the Myers and Stauffer audits, because they're the only
4 contractor that's been doing them, but those audits, you know,
5 the statute currently reads something to the effect that, you
6 know, there will be a statewide sample of providers, you know,
7 within this audit.

8 So you know, that has, I think, led to, you know, a sort
9 of -- a more generalized sample being taken. I think when you
10 look at the statute saying, you know, statewide sample, it
11 doesn't say, you know, target those high-risk areas, which is
12 something we could do a better job of, is targeting, I think,
13 those providers that really generate, you know, more findings,
14 really.

15 So you know, does it make sense to continue to audit
16 state, in-state, inpatient hospital providers when you have
17 very few findings. These larger organizations often have far
18 better internal controls. They have a myriad of oversight
19 agencies working with them and ensuring sort of quality and
20 frankly, we have very few findings when we talk about in-state
21 inpatient hospitals.

22 We pay them on a per diem basis. We're not paying them
23 via DRG, which is a -- in fact, that's a -- that was a big
24 reason why our RAC contractor is kind of unimpressed with the
25 state of Alaska because one of their biggest things they do is

1 go out and look for inpatient hospital DRG overpayments and
2 our payment methodology in the state of Alaska doesn't include
3 DRGs. So they kind of have been lost when they come to Alaska
4 and say, "Okay, well, what else can we do?"

5 So those are, you know, the targeting of provider types
6 and maybe, I don't know if it's a targeting of some, but maybe
7 the reduction in audits of certain provider types. It
8 certainly would make sense from, you know, from a sort of
9 strengthening and improving our process point of few.

10 As far as streamlining goes, we have -- we had some
11 thoughts on streamlining, as well. The -- let's see,
12 reducing, basically reducing the cycle time between an audit
13 notification and the final audit, if that cycle time is
14 reduced, that's something that we've been working toward.

15 Currently, we're somewhere in the neighborhood of 12 to
16 13 months for a cycle. So that's from an initial notification
17 of an audit to the -- to the final audit being released and I
18 think, you know, a reasonable goal in this could actually be
19 to essentially cut that in half.

20 Some of the strategies that we were thinking of to use in
21 order to do that, include sort of bringing communications,
22 being more proactive with communicating with the audit, the
23 folks that are being audited, including telephonic entrance
24 conferences before they get noticed, sort of, you know, what
25 are your questions, I mean, as soon as they get -- typically,

1 as soon as a provider gets a packet in the mail saying, "Gosh,
2 you know, congratulations, you've been selected for audit,"
3 the phone starts ringing, not only at my desk, you know, my
4 office gets phone calls. The Myers and Stauffers' office
5 starts getting phone calls and if we were more proactive about
6 pushing out information, I think that would be helpful and
7 we've been working with our contractor on that, as well.

8 Another strategy for reducing cycle time includes an
9 online dashboard for providers and for the state, quite
10 frankly, to go in -- be able to go in online and see where
11 exactly what the status of an audit is. I sometimes get phone
12 calls before, "Hey, you know, I sent in information, you know,
13 six weeks ago, what the heck's going on," you know, and
14 rightly so. I mean, they're interested in finding out, you
15 know, as soon as possible any potential impacts, you know, to
16 their bottom line and if we had, you know, sort of, you know,
17 an ability to just go in online and look at these things, I
18 think that would help reduce provider concern and stress, as
19 well as keep us more accountable with regard to ensuring those
20 cycle times, the targets are met.

21 So those are -- those were some of the things I just
22 wanted to throw out there and I'm sure interested in seeing if
23 you guys have other ideas and other questions.

24 CHAIR HURLBURT: I'm wondering, maybe we can go on to
25 Andrew. We probably have about 10 more minutes, I guess,

1 because we have two other discussions to come and then we can
2 come back to the questions. Doug, thank you very much.

3 MR. JONES: You bet.

4 MR. PETERSON: Okay, is this better, all right. Well,
5 thank you all for having us back again. I do appreciate it
6 and I won't go over everything that we addressed last time,
7 what the Medicaid Fraud Unit does and kind of to repeat, but
8 to, you know, the two issues that it sounds like you were
9 really interested in from the Medicaid Fraud Unit is really
10 collaboration and how to strengthen the enforcement that we're
11 doing and it's -- I think that's really interesting because
12 the word I kept hearing today while I was in the audience was
13 collaboration and how working with other units or other
14 individuals helps to prevent fraud and reduce the cost.

15 I had given you a few numbers at our last meeting of the
16 number of prosecutions we had, where we were currently at. I
17 had projected that I thought we had a few more coming. I'll
18 just give you a little bit of an update there. Since October
19 of 2012, we've filed 93 criminal cases in the state of Alaska.

20 We have 62 convictions with respect to state
21 investigations. We have suspended -- well, let me rephrase
22 that, because I get that wrong all the time. We have provided
23 Program Integrity with information about our investigations,
24 which allows Program Integrity to reach the decision that
25 there is a credible allegation of fraud and thus suspend the

1 provider.

2 As a result, five agencies have been suspended based on
3 state investigations. That included one physician and two
4 companies have been suspended based upon federal
5 investigations. In all seven of those, the investigations
6 have been jointly worked between state and federal agencies,
7 Program Integrity, Quality Assurance, just about every unit
8 within the Department of Health, multiple other state and
9 federal agencies.

10 The result of collaboration, I think, in our current
11 investigations, can best be seen with one case that we have
12 going. I've heard mention, you know, the home health care
13 industry. We have one large case going against one provider.
14 In that case, we have charged 53 individuals. That includes,
15 of the top management, the owners, office manager, the billers
16 and the, what are they called, client managers. There's 18
17 individuals that are management in that company. Fourteen
18 have been charged currently.

19 It resulted in 53 convictions to date. We have a number
20 -- or 35 convictions. We have a number of pending resolutions
21 that will be coming up in the next month or and it is
22 identified just in overpayments or fraudulent billing,
23 \$743,000. That case alone, based on the statistics we had
24 last time, estimated a cost savings of over \$12 million for
25 the state of Alaska.

1 One thing I would tell you that we're seeing is in our
2 ongoing investigations, we, you know, we use a number of
3 resources at our disposal, some of which is imaging cell
4 phones, computers and when we start looking through that
5 evidence, we see communications between providers saying,
6 "We've got to watch this type of conduct because," and they're
7 referring to other convictions.

8 So the activity of both of our agencies is definitely
9 getting the attention of certain provider types. They're
10 aware of it. They're talking about it and I think at the end
11 of day, it's going to reduce fraud in a lot of areas that
12 we're never going to be able to measure.

13 When it comes to collaboration, just to kind of give you
14 an overview, because you know, I know that's one thing you're
15 interested in, part of the reason I was asked to do this job
16 was because I'd done this previously in another position with
17 other agencies, but you know, prior to October 12, there
18 wasn't a lot of cooperation between Program Integrity and the
19 Department of Health and the Department of Law, unfortunately,
20 the Office of Inspector General had moved their federal agents
21 out of the state of Alaska because they didn't have enough
22 work for them.

23 They're regretting that now and they're just -- there
24 wasn't a -- unfortunately, there wasn't a free-flowing share
25 of information between agencies the way there should have

1 been. That's changed. I mean, we free share information back
2 and forth. We're both health care oversight agencies. We
3 have the ability to share information freely with one another
4 in our ongoing investigations.

5 One of the key things we've started to do with Program
6 Integrity is as soon -- it seemed, at least from my point of
7 view, historically, the prior director would wait in a
8 criminal investigation until charges were filed before asking
9 if a credible allegation could be reached by Program
10 Integrity.

11 Now, what we're doing is as soon as we've executed a
12 search warrant or essentially to say, "The cat's out of the
13 bag," it's no longer a surprise that we're looking at a
14 provider, at that time, we provide everything we have,
15 generally Program Integrity has everything long before that,
16 but they are then, you know, I send what's called -- a letter
17 over saying, "There's no more reason to -- for a law
18 enforcement purpose to not suspend this provider if you can
19 reach a credible allegation," and at that point, what we're
20 trying to do is suspend providers well ahead of criminal
21 charges so that we're not sending out good money after bad .

22 One of the reasons I say that is because a lot of the
23 agencies we're investigating are on really a cash flow basis.
24 I mean, it's cash in, cash out and there's nothing in the bank
25 and so if we wait, we're just spending more money. We're not

1 going to get any of that back and so we're really trying to be
2 as aggressive as possible in stopping the fraud, the waste,
3 the abuse and just to cut off the tap when it's justified.

4 I'll tell you, in all the suspensions we've had in the 93
5 criminal cases, everybody has received the suspension from
6 being able to be paid by Medicaid. With respect to the seven
7 agencies, only one of the agencies started to appeal. They
8 have a right to go to an administrative law judge and appeal
9 the suspension and that is generally because it's a business,
10 because there's a lot at stake, the administrative law judges
11 will generally expediate the process and will get them in
12 quickly.

13 One agency appealed and they went through their appeal
14 after a few weeks. So I would say that we are definitely
15 working closely to not -- I mean, we're trying to be very
16 judicious about how we use the suspension process and I think
17 we've been successful to date so far. We haven't had any
18 instances where we've overstepped our bounds.

19 So you know, I would say going -- following up on
20 collaboration with Program Integrity, one of the things what
21 we've been doing at the Department of Law is we're hiring, as
22 you heard, I believe it's Dr. Gerard, the prior speaker.

23 CHAIR HURLBURT: Dr. Grundy.

24 MR. PETERSON: He was indicating that their Director was
25 -- Grundy, I apologize, thank you. He indicated their prior

1 Director and their current Director are both from a law
2 enforcement background. That's what we've been trying to do
3 at the Department of Law is we're hiring investigators.

4 We're bringing in individuals with substantial law
5 enforcement experience. Unfortunately, that means they don't
6 generally have health care experience. So what we're doing is
7 we rely extensively on Program Integrity, for example, to
8 assist us.

9 Doug's auditors are doing a number of audits for us right
10 now and they're working with us on a daily basis on all of our
11 cases. When it comes to Quality Assurance, it would be
12 Director Mayes' group. Lynne Keilman-Cruz within Quality
13 Assurance has referred an unbelievable number of cases to our
14 unit. She's directly responsible for the one agency case
15 that's resulted in the 53 convictions or 53 charges. That was
16 her being in the field, seeing something that didn't seem
17 right, bringing it to us and then collectively, Lynne, Doug
18 and I kind of got together and advised an investigative
19 process to kind of start looking at that one particular
20 agency, based upon her referral that there was something going
21 on. She received information from an individual that didn't
22 seem right.

23 As I indicated with OIG, we're working with them on a
24 daily basis. We had two agents in our office all week. We've
25 got agents coming back up next week and so we've provided them

1 with facilities in our office and we're -- they are actually
2 looking actively for office space back up here, because we've
3 created enough work for them and they're spending enough time
4 flying people, that they're -- which is a good thing.

5 I mean, it's -- it is, you know, I mean, I know there's
6 the state/federal conflict that happens quite a bit in other
7 areas, but honestly, when it comes to health care, since they
8 are paying for a big majority of it, since they have resources
9 and expertise that we don't, it's all in our best interest to
10 work together.

11 To that end, the Office of Inspector General has now got
12 a Special Assistant US Attorney from North Dakota that, and
13 this is new since the last time we spoke, he's a US attorney
14 that's paid for by the Department, federal Department of
15 Health and they have got him assigned part-time now to come to
16 Alaska. He's being sworn in next month and he's going to
17 start assisting us with some of our larger cases and this will
18 prove to be helpful, because when it does come to federal
19 sentencing, as you heard your last speaker say, the feds do
20 send people to jail for a long time.

21 So it will bring additional pressure to bear on
22 individuals that are committing fraud. It will also make the
23 state's job easier in investigating and prosecuting cases
24 because we'll have other resources to rely upon.

25 Then, as I indicated previously, you know, we're working

1 with a lot of different agencies. So I know that the
2 Commission's concern is collaboration. We are reaching out to
3 all the agencies that we can to collaborate, where anybody who
4 has any resources that they can provide us or that we can
5 assist them with, we're doing that on a daily basis, just -- I
6 mean, we have limited folks.

7 I've got six investigators. Doug's got five, six
8 analysts within his office and so by utilizing, you know, kind
9 of collectively, all of our resources and using the
10 investigators within Quality Assurance, they have, as I've
11 been informed, they have a lot of other jobs that they're
12 supposed to do, as opposed to just assisting us, but we rely
13 on them as much as we can and there's been some really good --
14 just some side benefits from the prosecutions.

15 One of the things that we're seeing is that when we walk
16 into court now, the judges recognize the investigators.
17 They're seeing them for enough search warrants that as soon as
18 they walk in, they know what the warrant's about. They're
19 seeing our cases. Judges are starting to comment on the fraud
20 and the pervasiveness of it when they see yet another home
21 health care case coming before them. It's causing the court
22 some concern and that brings us all to, you know, different
23 schemes that we're seeing.

24 Doug kind of mentioned some of them. Realistically, the
25 biggest thing that we're seeing is, when it comes to Medicaid,

1 is that providers in different areas, whether it be home
2 health care or in the case of our physician case, for example,
3 is they're exploiting weaknesses in the system and weaknesses,
4 one of them being, for example, the individual recipients
5 don't have skin in the game to the same extent -- I know you
6 were commenting how you realized the difference in bills when
7 you started looking at them.

8 Well, you looked at them because you got an explanation
9 of benefits and you've got a copay, to some extent, and you're
10 making sure that it's right. Well, when it comes to Medicaid,
11 there's not an explanation of benefits that goes out to the
12 recipients and they really don't have the same skin in the
13 game.

14 So what happens is like, for example, in the physician
15 case that we have going on right now, it was easy for the
16 physician to bill for additional services not being provided,
17 because nobody was checking.

18 Similarly with respect to enrolling everybody who's
19 providing services, it does a number -- I mean, if we can -- I
20 recognize and I talked with Doug about this extensively and I
21 recognize there's costs there or outside of my desire to have
22 more tools at my disposal to prosecute fraud, waste and abuse,
23 there are realities of the system. So it's not flip the
24 switch and we have everybody enrolled within the system, but
25 one of the things that we're finding is when somebody can be -

1 - if they're enrolled in one area and they're reporting time,
2 they can do that, but then they're billing us in another area
3 and we have no idea about it.

4 Once we find it and we start matching up the hours
5 they're working, it's amazing how some people can work 30, 35,
6 39 hours in a day. I need that kind of skill because -- so
7 there's -- that's where the benefit is and if you think about
8 it when you look at other areas within the state, whether it
9 be sport fishing guides or rafting guides or hunting guides or
10 just anything -- any kind of service anybody provides,
11 generally, there's some kind of enrollment or registration or
12 licensing requirement and it doesn't have to be significant,
13 but as long as we are able to capture that information, it
14 will dramatically, I think, save the state of Alaska money and
15 that's one of the fastest, the home health care, the waiver
16 services is one of the fastest growing areas and I think, in
17 part, because it can be exploited.

18 The same thing can be said for some of the areas with
19 behavioral health. It's -- the difficulty for me, as a
20 prosecutor, in those areas and, you know, I am working with
21 the Department of Health on a regular basis to try and address
22 these issues, but it's the, essentially the vagueness of some
23 of the regulations that I have to deal with and so if the
24 regulations aren't really clear as to what can and can't be
25 provided, what can be billed for, what can't be, and a

1 limitation, then it makes my job more difficult and quite
2 honestly, it makes the Department's job more difficult in
3 recovering overpayments, or you know, identifying waste, fraud
4 and abuse because it's -- if it's not clearly defined what you
5 can and can't do, it's hard to hold a provider responsible for
6 a certain conduct. The.....

7 CHAIR HURLBURT: I think we're probably getting a little
8 short on time.

9 MR. PETERSON: Okay.

10 CHAIR HURLBURT: This is really good. I wish we had more
11 time, but yeah (affirmative), thank you.

12 MR. PETERSON: Okay, you know, if I could -- would have
13 the chance to stress two real quick issues?

14 MS. ERICKSON: Just a second, Ward, we might not need a
15 full hour and 15 minutes and we could go a little bit into the
16 -- we have a full hour for lunch. We could maybe cut a little
17 into that time, too, so just keep that in mind and if you feel
18 like we need a little more time, I think we have some
19 flexibility.

20 CHAIR HURLBURT: Yeah (affirmative).

21 UNIDENTIFIED SPEAKER: Yeah (affirmative), I would like
22 to hear what he has to say.

23 MR. PETERSON: I apologize, I didn't.....

24 CHAIR HURLBURT: No, this is good and we appreciate it,
25 Andrew, go ahead.

1 MR. PETERSON: The -- I guess just real quickly, the
2 changes that we've implemented collectively have been the
3 increased prosecutions, but also the increased administrative
4 proceedings. We're starting to, as I indicated, do the
5 suspensions on a more regular basis, but what we're also doing
6 is we're starting to initiate now, through Doug's shop, in
7 conjunction with the filing of a criminal charge, we're, for
8 example, against a home health care attendant, we're filing an
9 administrative overpayment notice against the provider and the
10 reason for that is, you know, the providers have signed the
11 documentation when they get their state warrant saying these
12 services were provided.

13 If we've got proof that the individual didn't provide
14 those services, we're not going to get the money back from the
15 individual, generally, so we go back after the agency. We're
16 -- if we do this right, we're able to collect the money back
17 from the agency before we even have the criminal defendant in
18 court to appear for their arraignment. So we've already got
19 our money back, number one.

20 That does two things for the state. One, it gets us our
21 money back. Two, it causes the providers to have some serious
22 skin in the game in the sense that they have to give us the
23 full payment back, but they've already paid their employee,
24 for example, \$16 an hour for the services. So now, whenever
25 fraud happens that we're able to identify, the employer's

1 going to be out, you know, 40, \$45 an hour when they only
2 received \$20 or 24 from us.

3 So what it does is it -- they're essentially paying for
4 the service twice. They're giving us our money back, plus
5 having paid and it's -- it results in -- it's been very
6 interesting to see and because providers have been resistant
7 to wanting to give us the money back. We won, or I shouldn't
8 say "we," but Doug's shop and the civil attorneys won an
9 administrative hearing where the AOJ said, "No, it's -- I
10 mean, the services weren't provided. You said they were.
11 You've got to pay the money back," and that's going to have, I
12 think, a direct benefit because it will result, not only in a
13 reduction of fraud, waste and abuse, but in employers actively
14 looking for it and really kind of coming onto our side when it
15 comes to this because they'll have an incentive to avoid it,
16 where in the past, there was an incentive to ignore it,
17 because even if the individual was caught, they still kept
18 their money. So we're trying to address that.

19 Last, just with respect to the audits that you heard, you
20 know, Doug Jones is doing, generally, they haven't resulted in
21 criminal prosecutions, but there's two really positive aspects
22 of it are -- yeah (affirmative), I guess two. One, we had a
23 recent audit that has identified fraud and there's a pending
24 case. The employer or the agency has been suspended based
25 upon the fraud identified by the audit. So that's been good

1 and it is a, you know, a significant savings of, I think, well
2 over a million dollars a year that the state will realize
3 because of that, but the second thing that we're noticing from
4 that case, as well as others, is when we identify fraud and
5 then we start auditing the employer further, especially using
6 Doug's shop, we've done this in a couple of cases, the amount
7 -- if the employer's already committing fraud, or the agency,
8 the amount of fraud that we're finding based upon -- or the
9 overpayments, we're finding based upon the audits is also
10 significantly increasing the return to the state of Alaska, so
11 a couple of real positive aspects from the audits that we've
12 seen.

13 MR. JONES: And frankly, Andrew, if we had you around in
14 past years, we would have had additional fraud cases from
15 those audits, too, so.....

16 MR. PETERSON: So and maybe, just a last thing, and I
17 don't know -- this is just kind of an idea that -- this is
18 just kind of an idea I was thinking as we were talking about
19 trying to get the money back and hearing the prior speaker
20 saying, you know, sometimes that's a difficult issue to do one
21 of the things we're finding in most of our criminal cases is
22 once we've charged an agency or a provider, they generally are
23 no longer in business at that point and we don't have a way to
24 collect or to capture that money.

25 So I don't know if there's, you know, politically or

1 legislatively, if there's an interest in a bond or some kind
2 of business insurance, but that's an interesting concept to
3 look at is how do we capture the money that's gone?

4 The second thing is there's, currently in state law,
5 anyway, there is very few avenues for seizure of assets or
6 forfeiture. The feds have very strong forfeiture laws and
7 seizure laws, but the state doesn't.

8 So for example, if we were to investigate an agency and
9 find fraud, they may own a building, they may have certain
10 assets or resources at their disposal and it would be nice to
11 have a clear mechanism for trying to, at least, place a lien
12 or somehow make sure that at the end of the day, if it shakes
13 out, following a criminal case that there was, in fact, fraud,
14 that the state has at least the opportunity to get some of the
15 money back that we've paid out along the way, because a lot of
16 these, as I indicated, a lot of these agencies are kind of
17 cash basis and once the tap is shut off by Doug Jones' shop,
18 it usually -- like I said, there's nothing there. So it's
19 something to think about.

20 CHAIR HURLBURT: Thank you. A couple of questions, Bob?

21 COMMISSIONER URATA: So this is -- this is for Doug and
22 then another one for Andrew, a second one for Andrew. So if
23 these folks are not auditing hospital charges, who's doing
24 that? If your RAC people are not able to audit DRGs, are they
25 auditing the fee-for-service part or the -- are they -- audits

1 are still ongoing? They just don't want to do it because it's
2 harder to do or.....

3 MR. JONES: I think it's wrapped up in the rate that's
4 really established. So in the state of Alaska, an inpatient
5 hospital within the state will submit a Medicare cost report.
6 That cost report will get reviewed for allowable costs and
7 then they will establish that per diem rate based on the
8 allowable cost associated with that provider and then, I think
9 they -- I think the current scheme is they inflate that
10 forward over a couple of years until they rebase the provider
11 and during that rebasing process, that's really -- that's
12 really the, you know, what goes into what you might consider,
13 you know, an audit of their charges, is if they're looking at
14 -- they're looking at the allowable costs and charges
15 associated with that hospital for that year and then they
16 establish that rate based on that audit.

17 So it's really in the -- in the rate setting process, is
18 really where the audit is. When someone like Myers and
19 Stauffer goes in and looks at them, they're looking for, you
20 know, okay, was the patient, I mean, you have the per diem
21 rates, so you have -- was the patient there that, you know,
22 for the night? Did they meet the midnight census, and
23 assuming that's a yes, did we pay them the appropriate rate,
24 and the only other thing that might be, you know, there would
25 be like a third-party payment or something that might look

1 for, which in, you know, in most inpatient hospitals, they
2 have, like I said, you know, pretty good internal controls.

3 COMMISSIONER URATA: So it's kind of hard to do fraud in
4 that situation, is that a fair statement?

5 MR. JONES: Yeah (affirmative), I think it is. I mean,
6 as long as you have, you know, really with the per diem
7 methodology, as long as you have a patient in the hospital at
8 midnight, and they bill what, you know, we pay them what we
9 should be paying them, boy, it's, you know, it's tough.

10 I mean, certainly, you know, I guess scenarios could be
11 had that, you know, medical necessity, you know, maybe they
12 didn't need to be there, but we also have a Qualis (sp) sort
13 of review on length of stay. If the length of stay exceeds
14 three days, we have a utilization review contractor that
15 ensures that, you know, they really need to be there. So like
16 I said, there's a lot of different oversights that go into
17 inpatient hospitals.

18 COMMISSIONER MORGAN: I think also -- I'm sorry, did I
19 jump the gun?

20 COMMISSIONER URATA: (Indiscernible - too far from
21 microphone).

22 COMMISSIONER MORGAN: I'm thinking I've been associated
23 over the last 25 years here in Alaska with organizations that
24 do cost reports and what you also find, and like maybe --
25 number one, the DRG issue, but most cost reports, as far as I

1 know, usually are done by some of the larger accounting firms
2 by their medical division.

3 So you almost have a compliance work up. So they
4 actually, when they come -- you know, we put our work papers
5 together, you -- you know where I'm going, right, we do our
6 work papers. In fact, I -- that's what I was doing yesterday
7 at 3:30 and then they come in and look at them, but they also
8 sample to make sure that everything is kosher.

9 Most of the time in inpatient hospitals, it's more -- not
10 a fraud thing, I think, but more of they just plain screwed up
11 thing sometimes. So the -- even the Indian Health Service
12 uses an organization of CPAs, medical, that come in, review,
13 you know, they actually do see -- take a random number system
14 and check the census reviewed at night. Was Dave in that bed
15 at night and cross check to the medical records.

16 So from the inpatient side, I think if there is any
17 fraud, it would be more of looking at was the justification
18 with Qualis, and I actually have a patient, but where you --
19 these are the forms. There's forms you fill out to get pre-
20 auth, if it falls into a certain area. I'm looking back at
21 the back, especially with Medicaid, but for also other
22 insurance carriers and that's submitted and then you get pre-
23 auth with a number to put on the bill.

24 So at least on the inpatient side, there's a bunch of
25 stuff that has to happen before you even get them, they will

1 draw up the consent. So that probably kind of cools that
2 down.

3 That's probably why the Lower 48, where I worked a few
4 years, it's not necessarily that good, especially with the
5 DRGs. Also, we're a small state. So if anybody is really
6 pulling any hanky panky, usually they get ratted out and
7 people -- these guys find out. There's a few and I -- I think
8 -- what I'd like for you to talk about for a few minutes is
9 the one I was in intrigued in Juneau was you had collaboration
10 with Immigration and ICE on checking where certain providers
11 were versus were they really there delivering the service.

12 The other is, I think, and I know Ms. Brodie will be here
13 in a few minutes, but I think virtually all providers, even in
14 the groups, will -- are enrolled, separately or there's a
15 process in the new billing system. Sometimes -- that's sort
16 of an area that I've worked in, billing, but I think a lot of
17 these, you know, group enrollment, you have one number, but
18 you may have 15 people billing under that number and it's up
19 to the provider to make sure they meet the qualifications and
20 you have the file and all that stuff and then they'll come in
21 periodically or if you fall on the random number chart,
22 they'll come in and pull them and look at them or you send
23 them to somebody to look at, but I think under the new MMIS
24 system, more of these groups, you're actually enrolling those
25 individuals inside that group into the system, but that's for

1 a later day, but take one minute, I thought that -- it was
2 almost, you know, CSI, in a way, of how you tracked down that
3 one.

4 MR. PETERSON: A couple of things OIG has definitely done
5 for us is provided us with lots of technical support. I mean,
6 so we have -- we have technical capabilities that are
7 phenomenal, for example, going in and executing a search
8 warrant and having their agents there and imaging 30 phones
9 and 16 computers in one day is something that I -- is pretty
10 difficult for just about any agency to do.

11 So that part is amazing and the amount of resources you
12 can -- or the evidence you can find from a search warrant like
13 that is fantastic. So obviously, we have to have Port
14 Authority to do that type of stuff and we seek that in
15 advance, but with respect to Immigration, what they've been
16 doing for us is assisting us when we have an ongoing
17 investigation.

18 We run the names through Immigration just to see if
19 there's been international travel and one thing we have been
20 finding a lot of, just due to the proximity of Alaska to other
21 parts of the world, people like to travel, whether it's been,
22 you know, we've identified people who have gone down to San
23 Diego and gone on a cruise to Mexico, because you go through
24 Immigration. So you know, here they are, they're out of
25 country for, you know, two weeks, but yet, we've been being

1 billed for the care they've been provided in the state the
2 whole time and so that has resulted in a significant number of
3 cases and Immigration has really been, to be perfectly honest,
4 they've been extremely helpful with us.

5 They're willing to assist us in cases. They appear at
6 grand jury. It's been, you know, really refreshing, the
7 assistance they've given us and whether it be Doug's shop or
8 Lynne's shop in Quality Assurance or Immigration, we've yet to
9 have somebody say, "No," when we've asked for help. So that's
10 been fantastic.

11 CHAIR HURLBURT: Two more questions, Larry and then Bob.

12 SENATOR COGHILL: So two things you brought up, Andrew,
13 the bond, I like that idea. So somewhere along the line, I
14 don't want to lose track of that, so I've made note of it and
15 then the forfeiture statutes, two very good ideas for a
16 legislator to hear and to know that, but what I don't
17 understand and what needs to be, probably, explored a little
18 more is the enrollment issue and I know the MMIS system is
19 struggling along, trying to get going, but is that a health
20 plan issue? Is it -- does it -- is it a state only issue?
21 How do we work with the federal government on their
22 requirements? Is that something that is an administrative
23 function first, before the Legislature can get involved? So I
24 just need to understand a little bit more about the enrollment
25 for your ability to track and maybe that's something that you

1 answer.

2 MR. PETERSON: Yes, I mean, there's probably a better --
3 I mean, how to do it is probably better -- is a better answer
4 for Doug to provide you. I mean, what I can tell you is once
5 they're enrolled, it makes our job substantially easier, but
6 I'll let Doug explain the -- that aspect of it.

7 MR. JONES: Sure, and I think, you know, with regard to
8 like the home and community-based waiver and the behavioral
9 health providers we were talking about, that population can be
10 basically, you know, if you have -- all it would take is
11 really a regulation change and that each state has that
12 ability within the parameters of their Medicaid program.

13 So it's something that wouldn't take, you know, it's a
14 big job. I'm not -- I mean, when we did -- when we enrolled
15 the PCAs, I mean, we went from sort of 9,000 enrolled
16 providers to about 18,000 because, I mean, there were 9,000
17 PCAs, which you know, that's a lot.

18 One of the, you know, one of the, I guess one of the
19 take-aways from that enrollment process, too, though, is
20 ensuring, too, that the -- that things like the background
21 checks are in place prior to enrollment, because we sort of
22 did it backwards last time and sort of enrolled all these guys
23 without ensuring that their background check was in place.

24 So we now spend a considerable amount of time going back
25 and ensuring background checks are there when they should be.

1 If that was done up front, you know, and of course, you know,
2 hindsight's 20/20, but if that was done up front when we
3 enroll the PCAs, boy, that would have been very helpful. So
4 it's something we can do with relative ease, as far as the
5 administrative requirement. The work involved is another
6 issue.

7 COMMISSIONER STINSON: A couple of comments, I wasn't at
8 your first presentation, so you may have covered some of this
9 before, but I've been on the State Medical Board, as well as
10 the Health Care Commission, and the thing I hear from
11 providers, PAs, nurse practitioners, physicians, is that under
12 the RAC concept, you're basically guilty until proven innocent
13 and they're worried about that because they don't get a
14 recovery unless they find something and so I've heard that
15 over and over and over again from many different providers and
16 then they often think about opting out of Medicaid, which is
17 not such -- then that just lowers the pool, particularly in
18 more rural areas where there may be difficult access and then,
19 one other point, and I think you can get this from providers,
20 you know, I'm an auditor for Medicaid for opioid use and so
21 far, we haven't approved anybody who's tried to get a waiver,
22 because they're trying to do the wrong things for the wrong
23 reasons.

24 We just pointed it out in the literature and so far,
25 nobody's even tried to do anything about it, but one of the

1 things that other providers notice and I've noticed, because
2 all of a sudden a bunch of Medicaid and Medicare patients are
3 released from a different practice and they're on the market
4 and they're wanting to know if you will take them over that
5 the providers who are dabbling in the gray, they don't really
6 worry about Aetna. They don't really worry about Premera.
7 They worry about Medicare and Medicaid and particularly,
8 Medicare, for all the reasons that you're just saying.

9 So all of a sudden, you're in practice in an area and
10 somebody just decides to wash out all of their Medicare and
11 Medicaid patients, you could think, "Well, low reimbursement,"
12 you could think, you know, "Being hassled and a lot of
13 paperwork," all of that's true, but it sure seems like a lot
14 of those people within a year or two sure wind up on the front
15 page somewhere and that might be another resource for you.

16 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
17 microphone), yeah (affirmative).

18 COMMISSIONER STINSON: It stands out in a small
19 community.

20 MR. JONES: That's an interesting concept.

21 CHAIR HURLBURT: I think Bob has a question.

22 MR. JONES: Just regard to the RAC real quick, so I know
23 on the Medicare side, there was substantial push back with
24 regard to the RAC and yeah (affirmative), I mean, the whole,
25 you know, the whole structure of that contract is

1 questionable, certainly in Alaska and I'm less familiar with
2 Medicare, but certainly with the Alaska Medicaid program, you
3 know, we do offer, you know, administrative hearings, and you
4 know, we did not jump out and really -- and I mean, it's kind
5 of, I guess the contractor wanting to quit is kind of a --
6 might be a, you know, a sign, but we didn't just jump out, and
7 you know, sort of guilty until proven innocent kind of way,
8 you know, an approach.

9 We took, I think, a more considerate approach to rolling
10 out our RAC contract and it sort of rolled out, sputtered and
11 is now kind of falling down, so we'll see.

12 CHAIR HURLBURT: Bob and then Allen and then we need to
13 move on.

14 COMMISSIONER URATA: Mr. Peterson, how many of the folks
15 that you see or look at in investigations are -- do you think
16 are truly bad apples versus people who are ignorant of the
17 rules, which is still a bad thing and -- but how many are
18 truly bad apples here in our state?

19 MR. PETERSON: Well, you know, I guess it's hard to give
20 a percentage. I mean, the last time I was here, I think they
21 put the percentage we talked about where the FBI says
22 somewhere between 3% to 10% of all medical billings are fraud,
23 that's their number. I don't know, you know, it's really
24 difficult to put a number on that.

25 What I would tell you is with respect to my criminal

1 charges for medical assistance fraud, I have to show that they
2 knowingly billed for a service with a reckless disregard, that
3 they weren't entitled to that service and I hear what you're
4 saying from a lot of defendants where they'll say, "I had no
5 idea it was wrong," and I kind of scratch my head and go,
6 "Well, you were not in the country and you were billing for
7 services while your recipient was here," and -- or you know,
8 worse yet, let's say the recipient traveled with him and so
9 they were together, which violates the rules and they say,
10 "Well, we were together," and I could almost buy it, except
11 for then they'll submit like a waiver service bill for
12 transportation, but they're not saying we were in another
13 country providing transportation. They're telling us they
14 were driving him all around Anchorage. So they're flat lying.

15 So part of the problem is -- and it's one of the things
16 I'm working on with the judges, is you know, the judges will
17 see three, five, 10, \$15,000 in fraud and they're kind of
18 debating whether or not they put somebody in jail for that
19 type of conduct, because generally, the people we catch don't
20 have any criminal history. Their first-time offenders, but
21 what I remind the court is, you know, if somebody walked out
22 of Wal-Mart every day with a \$500 TV or once a week with a
23 \$500 TV for weeks or months, we would probably throw them in
24 jail and what they're doing here when it comes to Medicaid is
25 they're submitting false bills month after month after month

1 and sometimes this goes on for years.

2 I mean, we -- I do have a sentencing on Monday of a lady
3 who's fraudulently billed \$94,000 over the period of a couple
4 of years and she had 258 days in 2011 in which she billed in
5 excess of 24 hours a day. So when it comes to something like
6 that, I have to believe it's just intentional.

7 Now, there are -- we have come across cases where we've
8 either charged and then we've -- we've had a couple of cases
9 where we've charged and we have the evidence, but we look at
10 it and we go, "Okay, we could see this being -- we could see
11 an argument here."

12 Generally, a case like that, though, where we think there
13 might be an argument that this was a mistake or they just
14 didn't understand, we will work out a civil resolution in
15 advance. I'll work with the administrator, the civil side,
16 with Doug's shop, we've done some things where we've limited
17 providers to what type of service they can provide for a few
18 years. They can get relicensed subject to payment back.

19 I mean, we -- if I don't believe that I can prove the
20 case beyond a reasonable doubt, I don't charge and we will
21 address it in another manner.

22 COMMISSIONER URATA: Thank you.

23 MR. PETERSON: You bet.

24 CHAIR HURLBURT: Okay, thank you very much, once again,
25 the real (indiscernible) that you brought to us, so a lot of

1 interest and we appreciate it and again, we, as Alaskans, we
2 all appreciate what you're doing. So thank you.

3 MR. PETERSON: Thank you for your time.

4 CHAIR HURLBURT: I think we'll go ahead and take a break
5 now and then we'll come back with Margaret and Lydia.

6 MS. ERICKSON: And just a quick warning for Commission
7 members, this means we're going to probably have a working
8 lunch and not take much of a break during lunch.

9 10:39:33

10 (Off record)

11 (On record)

12 10:57:24

13 CHAIR HURLBURT: Yeah (affirmative), let's move on.
14 We're running kind of late and I think you're going to really
15 enjoy the next session. So if we could gather around the
16 table, please?

17 Okay, let's go ahead and start. The next session
18 represents a little bit of a metamorphosis in that we've been
19 talking about fraud and abuse. I think Medicare, on the
20 fraud, sometimes, uses a number of 3%, which would be like
21 \$100 billion a year nationally, so a lot of real money, and
22 we're all fascinated by what Gordon and Andrew shared with us
23 here and we're all incensed because we are in a business that,
24 as I like to say, has unique moral and ethical dimensions and
25 there's not room for fraud anywhere, but especially in this

1 business, there's not room for fraud and that's why, I think,
2 we all appreciate so much what they do, but what's so -- we're
3 still in the fraud and abuse section, but we're really
4 metamorphosing a little and what I'll do is invite Margaret
5 Brodie and Dr. Lydia Bartholomew, maybe both to come up to the
6 table now, but we'll start with Margaret talking about
7 Medicaid claims management.

8 Medicaid claims management clearly is one of the places
9 where there's a window where we find indications of potential
10 fraud and abuse there, but it also is more than that and it's
11 -- to use the formal terms of our economist colleague here, a
12 hospital bill frequently has screw ups and the numbers that we
13 used to use was the expectation would be, on the average, a
14 hospital bill, an itemized bill, would have 15% errors in it
15 and I think we're doing better today, but there are the screw
16 ups there and they're not intentional.

17 They're not nefarious or deliberate, but it does happen
18 and so this is one of the checks and balances on the system
19 there. It also looks, is this a covered benefit, because that
20 can be very confusing to patients, providers, and everybody
21 else, but again, an example I've used before, if your house
22 burns down, that's a tragedy and we feel for you, but we don't
23 expect your health insurance to pay for that, but -- so what
24 is the covered benefit and we look at that there and there's
25 the mechanics of it.

1 Obviously, medical claims management is also very
2 important to a payer and Margaret has had as big a challenge
3 as anybody in this universe dealing with the MMIS issues and
4 she's been incredible with just kind of keep it on a cool even
5 stance and doing that, but what it points out is how you do
6 claims management is a huge source of provider satisfaction or
7 dissatisfaction and how you manage that and so that's that and
8 then we'll move on next, talking about medical management and
9 we talked some about talking about the what, whys and hows of
10 medical management and we don't have time for that now, but
11 medical management is another area where you can get a window
12 in potential fraud, but much more than that, vastly more than
13 that, it also does two other things.

14 One is it helps assure and improve the quality of care.
15 It's where you look at evidence-based standards and for
16 example, I haven't even mentioned it to Dr. Bartholomew when
17 we talked the other day, but I was asked to look at a denial
18 and we're a small state and Juneau's a small town and so a
19 patient was complaining because there had been a denial that
20 you had been involved in, Lydia, and since everybody knows
21 everybody there, the complaint got to a high level person and
22 came to me to look at it and I did not look at the clinical
23 information, which I know you did, but what it was, it was --
24 there had been a partial approval of the request for services
25 and the denial of another portion of the services and the

1 portion that was denied, without knowing the clinical details,
2 so I had to kind of talk philosophically in my response, but
3 was -- it's the kind of thing that one, there's huge profits
4 made on, that there are some things that almost border on
5 fraud there in the way that there's ownership of manufacturing
6 firms and so on and the outcomes are poor and so I said, "I
7 don't know, because I didn't see the clinical papers," but my
8 intuitive feel was that yes, that Dr. Bartholomew was
9 protecting the resources of the state going through Aetna
10 there and assuring that they were used in a proper stewardship
11 way, but she also was protecting the quality of care and
12 protecting the interest of the patient there and it doesn't
13 always seem like that to the doctor and it doesn't always feel
14 like that to the patient, but it is one of the very important
15 places to bring in evidence to assure quality care and then
16 the stewardship of resources is one -- we started talking
17 about the total magnitude of health care, \$3 trillion
18 annually, and we all need to be sensitive to that, but also,
19 that individually, whether you have an employer at risk like
20 the state or whether it's Aetna or Premera or somebody else
21 and their total book of business where they're at risk, you
22 need to be prepared for some of the things that we can
23 marvelously do now, like the severely premature 24-week baby
24 that gets to a Level IV NICU and is going to cost you a couple
25 of million dollars.

1 Where are you going to get it? You've got to get it out
2 of everybody's premium, or the fisherman in Bristol Bay that
3 gets a 60% body burn and goes to Harborview, where they can do
4 incredible things, but a couple of million dollars probably,
5 by the time you get through there and so that's got to come
6 out of the premiums.

7 So that's -- medical management is that and that kind of
8 moves away from fraud. So that's the introduction that's
9 under fraud, but this is now kind of expanding beyond that.
10 Margaret, if -- we turn to you.

11 MS. BRODIE: Thank you. I'm Margaret Brodie. I'm the
12 Director of Health Care Services for the State of Alaska and
13 so I was asked to talk about what we do to help with fraud and
14 to prevent fraud and what kinds of activities we have going on
15 in Medicaid.

16 So one of the first things that we have that's a tool
17 that we use is the prior authorization. We have a lot of
18 different types of services that require prior authorizations,
19 high cost imaging, travel, and DME equipment, PCA services,
20 chore services, the waiver services all require prior
21 authorization and so the prior authorization is supposed to be
22 looking at the medical necessity of what they're asking for.
23 Is that medically necessary, yes or no.

24 So for travel, when you're looking to travel, are these
25 services available in their community, yes or no, and they

1 should be getting the services at the closest facility that
2 can provide it or provider within -- where they live, but
3 then, you also have individuals who have literally blown out
4 all of their providers in their area. Nobody will see them at
5 all and so, we do end up having to travel some people that we
6 shouldn't, but there isn't a provider. There isn't access to
7 care in the area that they're in.

8 The next thing that we -- a tool that we do have for some
9 cases, and Senior and Disability Services uses this,
10 Behavioral Health uses this and Health Care Services all use
11 it, is if we believe that there's an issue with the billing of
12 specific providers, we put them on prepayment review and what
13 that means is that, though claims will all go into the system,
14 but they're going to suspend and somebody from one of our
15 agencies is going to go through all of their claims, through
16 their documentation and see, should those claims be paid or
17 not and literally, release them one by one and at any point in
18 time, we have about a dozen providers on prepayment review.

19 It's a very painstaking process but this is for people
20 who have billed for services inappropriately multiple times.
21 They owe a good amount back because they've billed to a point
22 where we can't prove intent that it was fraud, but we provide
23 additional education, put them on a prepayment review and for
24 the majority of these providers, we can work them off it in
25 four to six months where they're billing appropriately and

1 correctly, but it does take one-on-one intervention with these
2 providers.

3 The next thing that we have is we do have -- it's called
4 SURs, Service Utilization Reviews. So what we're looking for
5 is we're looking for a provider that's an outlier from
6 everybody else. Are they billing for something, you know, ten
7 times more than every other of their type of provider.

8 It -- an example would be tobacco cessation counseling.
9 Are they billing it for every single Medicaid recipient that
10 they see? Are they billing it for two-year-olds? Are they
11 billing, you know, that's the kind of thing that this looks
12 at.

13 So any time that we see an outlier, we have a whole team
14 over at Xerox and we have a team in Health Care Services and
15 so we look out at the universe of claims and if there's
16 anybody that's an outlier, then we put them in the queue to be
17 investigated.

18 So what we do with that is we go ahead and we request
19 medical records to see if what they were doing was medically
20 necessary. This is a pretty big burden to the providers to do
21 it the way that we're doing it because they ask for the entire
22 history of the patients that they billed for and in reality,
23 we only care about what's outlying. So those are the records
24 we need. So we are actually in the process of revamping our
25 SURs, how we're going to do it, because it takes 12 to 15

1 months to get through that process from beginning to end right
2 now and that could be 12 to 15 months that we're paying
3 somebody for services that they shouldn't be paid for.

4 So we're going to be targeting just the outlying service
5 that's being provided and be able to get those medical records
6 faster, maybe even do onsite visits to go pick up the medical
7 records so that we can shorten the timeframe.

8 The other thing that we look at are our over-utilizer --
9 recipients over-utilizing and right now, we had a super
10 utilizer project that we're working with, with the National
11 Governors' Association and we identified a large universe of
12 recipients that over-utilize the emergency rooms.

13 So we've put together a project right now and it's called
14 the Alaska Medicaid Care Coordination Initiative and
15 literally, the letters are going out to these people today in
16 the Anchorage and Mat-Su Valley asking them to volunteer for
17 this program. It's a care coordination program.

18 Every one of these people qualified for what we called
19 the Lock-In Program, but we don't have the resources, neither
20 ourselves or Xerox has the resources to care manage this many
21 people. So we're putting it out there. We're hoping to get
22 people to volunteer. We're pretty sure they will because
23 we're offering a service to them. We're offering to help them
24 navigate the medical community and for them to get the
25 resources that they need.

1 We will be brining in -- we originally thought we were
2 going to bring in 1,600 people into the program. Our RFP just
3 closed two weeks ago and we had four entities apply. We think
4 we're going to be able to target closer to 5,000 people in
5 this initiative.

6 So we have three letters going out. One, you know,
7 here's this nice, wonderful program that you qualify for and
8 literally, I want to enroll -- not at this time and so we have
9 a series of three letters that are going to go out. So
10 hopefully, we'll be able to fill it voluntarily. If not, we
11 do have the Lock-in Program that we can use to fill up the
12 rest of the slots that we want to do .

13 So those are just some of the ways that we use claims and
14 I do want to say with this super utilizer project, be on the
15 look out in September because Alaska is going to be
16 highlighted in a national article going out on data analytics
17 and how we identified these people and the program that we put
18 together for the people who are awarded the RFPs to report the
19 information back to us. So that's going to be really
20 interesting.

21 Another thing that we're working on right now, and it's -
22 - I'd say I'm a week behind schedule, is we identified all the
23 people who traveled on Medicaid, but didn't attend a medical
24 appointment and so I'm going ahead and I'm sending them a
25 letter saying, "Hey, you traveled from here to here on these

1 dates for medical reasons, apparently, so please provide
2 verification that you attended a medical appointment. If not,
3 this is the dollar amount that you owe Alaska Medicaid."

4 So there is one person, actually, that took 72 trips
5 without one medical appointment. So I'm going ahead and
6 there's going to be two letters. This one going out -- what
7 took so long is I, of course, had to get it through legal. So
8 I have both letters. The last one was just approved by legal
9 this last week.

10 So the first one says, "Hey, you traveled. Please
11 provide verification that you attended a medical appointment,
12 if not, you're going to owe Alaska Medicaid this much." The
13 next one that goes out is, "Hey, you didn't provide the
14 verification. You have one more chance to do it, if now,
15 we're garnishing your Permanent Fund Dividend," and so I will
16 be providing a list to all the tribal entities in the state of
17 their members who are on this list.

18 I think out of this, also, as we take a closer look at
19 it, there actually is potential for some fraud on the behalf
20 of some people that were approving the travel. So we are
21 looking at that closely.

22 Another thing that we're working on is cash for drugs.
23 For -- we want to change the regulations to make it so that
24 anybody that's on Medicaid cannot pay cash for any other
25 prescription drugs. They can pay for over-the-counter, but

1 not for prescription drugs because we have Medicaid members
2 that go in and they literally have two prescriptions with
3 them. They have one for their Medicaid and then they have one
4 that they're going to pay cash with.

5 Well, if they have the means and resources to like pay
6 cash, like \$1,000 for their prescription, they probably don't
7 quality for Medicaid. They have income and resources that
8 they're not reporting. So we want to make it so that if the
9 pharmacist knows that the person is on Medicaid, they cannot
10 be filling prescriptions for them for cash.

11 We have an RFP in procurement right now in the final
12 stages of being written for the electronic visit verification
13 for PCAs. It's a pilot project that we're doing in the
14 Anchorage area. I think we're probably five months out from
15 getting it on the ground and so this is where the PCAs, when
16 they go into somebody's home, they have to check in
17 electronically. They're going to have to check out
18 electronically and we're going to be able to run this
19 information against the Medicaid claims to see, is this what
20 they're billing for? Does it match? Are they billing for
21 more? Are they billing for less? We'll be able to get a
22 better picture of what's going on.

23 Let's see, we just -- we've been working on enrollment
24 issues with our providers. Right now, everybody had to re-
25 enroll for the new system, but at the time, it was such a

1 massive effort that people didn't get ownership information on
2 the providers. So we don't have the interrelationship from
3 one provider to the next to the next. You could have husbands
4 and wives. You could have one person that owns multiple
5 entities and so we're in the process -- we're under --
6 actually under a corrective action plan right now to get
7 ownership information on all providers and as Doug and Andrew
8 had mentioned before, the enrollment of the rendering
9 providers, the people that are actually providing the service
10 to the recipients is the way that we need to go to be able to
11 fully capture who's providing services, what services are
12 being provided, is the correct person providing those
13 services, and so we hope to be able to do that in the future
14 as next steps.

15 Then, I just wanted to let you know how much different it
16 really, really is with Andrew in fraud. There were a lot of
17 pieces that were completely missing from the fraud landscape
18 all together and we learned a few of them the hard way.
19 Andrew is very inclusive, works with all of our Medicaid
20 agencies. He actually includes our people in on the bus, I
21 mean, how many CPAs can say they kicked in a door, Doug?

22 So -- but it went even further, because what do we do if
23 we're going to suspend somebody for fraud? The ripple effect
24 of what really happens was never, never really known. We --
25 is that person -- is there a check waiting to go out the door

1 for that person for a couple of hundred thousand that we could
2 stop from going out? I mean, all these different connections
3 weren't made in the past and now they are.

4 We're able to go to the licensing agencies, whether it's
5 in DVH, Health Care Services or Senior Disability Services,
6 make sure that they're dis-enrolled in their systems,
7 collaborate to what's going on, get with background check
8 programs, bar them from participation, so that they can't just
9 go across the street and get another job and with one of the
10 busts, we found that not only did we need to suspend them
11 where they were employed, but they also owned three other
12 assisted living homes. So we had to suspend those also.

13 So the implications and the ripple effect of what goes on
14 was never known before, but now that we're all working in
15 collaboration, we know when a bust is going down. We have the
16 people in place to be sure that, okay, so this agency can't
17 provide services anymore, but we need to find services for
18 these recipients. So whose job is that? Who's going to
19 suspend the person? Who's going to look them up in the
20 databases to be sure that we've got them covered everywhere?
21 Who's going to stop that check from going out the door for
22 Medicaid right then and there? Who's going to go pull that
23 check and make sure that we, at least, can recoup this amount
24 if they go out of business?

25 So all of that is in place now and it's working really

1 well and that just was never there. So I can't tell you how
2 grateful we are for the cooperation that we now have with
3 Medicaid fraud.

4 CHAIR HURLBURT: Well, Margaret, for the situation that
5 you described where an individual goes with two prescriptions,
6 one for a controlled substance, one that Medicaid would pay
7 and another for cash, are you able to use the current Alaska
8 prescription drug management program to identify when that
9 individual goes to say Wal-Mart and gets the Medicaid
10 prescription and Walgreens to buy for cash?

11 MS. BRODIE: We are not. The only person -- we are
12 actually excluded from it in statute. The only person that
13 could, would be Andrew with a warrant. He has to get a
14 warrant. He doesn't have access either.

15 CHAIR HURLBURT: So the PDMP does not pick that up at any
16 place, as far as you're aware? Larry.

17 COMMISSIONER STINSON: Since we use that a lot in our
18 clinic, it's not real-time. So that's still a hole. They're
19 -- I'm very impressed. I -- Alaska's growing up. They're
20 closing off a lot of the holes. If you can go to a real-time
21 database, then you would close out -- close out that loop,
22 too, but that's still probably the number one way people
23 divert -- people sell their drugs. It's maddening and to this
24 point, to this, right now, it's still off the record, unless
25 it was two weeks ago.

1 COMMISSIONER CAMPBELL: Under that scenario of two
2 scripts, is there any blowback to the prescribing physician or
3 clinician?

4 MS. BRODIE: Unless it's reported to us right now, we
5 don't know about it. We do have pharmacists that report that
6 to us and we do pass that along.

7 CHAIR HURLBURT: But this is, as Margaret just pointed
8 out and as I mentioned, I said the same thing what Chad had
9 told me what you said and it was just kind of jaw-dropping
10 that you guys don't have access, that Chad doesn't have access
11 to the PDMP information, yeah (affirmative).

12 COMMISSIONER URATA: I thought that was in legislation to
13 get another (indiscernible - too far from microphone).

14 COMMISSIONER STINSON: It didn't pass.

15 COMMISSIONER URATA: It didn't?

16 COMMISSIONER STINSON: No.

17 COMMISSIONER URATA: That was (indiscernible - too far
18 from microphone).

19 COMMISSIONER HULTBERG: So actually, if I could ask a
20 question of Dr. Stinson, so I was talking to an emergency room
21 physician about the issue of drug-seeking behavior and at
22 least his view, and maybe it was just his view alone or maybe
23 it's the ER physicians, was that yeah (affirmative), it would
24 be nice to have the real-time data. It would be helpful. It
25 would be more useful, but what they were looking for was the

1 pattern of behavior, not -- and so I just -- you're the expert
2 in that and I wanted to just get your.....

3 COMMISSIONER STINSON: Sure, it's both. When you have
4 real-time, he can see at Providence if the person just left
5 Alaska Regional four hours ago and they're -- I've got a
6 horrible headache and I need more, but when it comes up, when
7 you get the printout, you not only get that day's event, you
8 get everything in the last several weeks.

9 So you get a pattern. You get current. You get a
10 pattern. Other states have done this. It's made a remarkable
11 difference in prescribing and overdose and all -- the domestic
12 violence it goes right through the community. It's made a
13 dramatic difference in these other places and Alaska, I know
14 everybody is always hitting the Legislature for money and I
15 get that, but this would make a big difference.

16 COMMISSIONER MORGAN: I know a lot of the -- a lot of
17 organizations that have health districts and provide services
18 have their own internal process of finding people that do what
19 you're describing, some do, some don't, but what I wanted to
20 ask, which she sort of knows this question's coming, because I
21 talked to her at the break, under the old system, the
22 rendering part, especially on -- for group enrollments like
23 PCA, which we've heard a lot about, you didn't actually have
24 necessarily all the people that were -- you could have 98
25 people underneath that number, have that -- some in behavioral

1 health, CHAPs is another example, I think the new system, as
2 you're working through it, corrects that, that you now put
3 them all in so you can track them all, is that -- have I got
4 it?

5 MS. BRODIE: Yes, sir, we have the ability to put the
6 actual render in the system now and enroll them as a provider.

7 COMMISSIONER MORGAN: I tried not to ask a question I
8 don't know the answer to. What I'd like to say is, I know
9 there will be push-back because what we're basically trying to
10 do is catch that 3% to 8% of the people that really -- every
11 profession has them, whether it's a police officer or in the
12 Army or in the medical profession, but I'm going to try my
13 best at, since I do a professional joiner-upper at all the
14 organizations I go to, beseech them all not to look at the
15 broad system issues here and every time there's a headline by
16 that guy in the back of the room as people providing services,
17 it really hurts our credibility when we go to Wes and to John
18 and say, "You know, we really need some more money to do this
19 or that."

20 The other thing is this is going to be -- just PCA added
21 8,000 or 9,000. These other groups are going to be big. I
22 would hope that you get the necessary resources. You could
23 only process by how many human beings you've got that can
24 process it and I hope they give you enough resources.

25 I know Xerox gives you some -- has some, but it might be

1 helpful to think about that, especially on the next budget
2 swing to give you enough people to get them in so everyone
3 knows they're in and maybe we'll -- the guy at the back of the
4 room will then won't have as much to do and he can actually --
5 he can go to Mexico with that and take a vacation. So that's
6 my two cents' worth on this.

7 CHAIR HURLBURT: Any others? Allen, last question, yeah
8 (affirmative).

9 COMMISSIONER HIPPLER: Thank you. I've some questions
10 about privacy. I didn't use to care about privacy at all, but
11 it seems like a lot of the times now I'm having concerns about
12 this. So you know, if you're on Medicaid, you go on travel,
13 that gets reported to the state and the state can forward that
14 to my Native Tribal Health Consortium or Native Tribal Health
15 and if I go to the -- if I'm on Medicaid and I go to the
16 pharmacist and I have a couple of prescriptions and I pay for
17 one with Medicaid and one with cash, that goes to the state
18 and if I over-utilize the ER, you know, I get on this list.

19 What kinds of privacy protections do people have who are
20 on Medicaid or is it just because society, as a whole, is
21 paying for their medical care, for whatever reason, they just
22 don't have any? Thank you.

23 MS. BRODIE: They do have privacy. Only the people
24 within Medicaid are the ones that know we don't publish a list
25 of people that super-utilize. We don't inform others. We

1 were asked by the tribes, specifically, so that they can help
2 their members understand what's going on, because a lot of
3 them don't speak English and the letter is going out in
4 English. So that's the reason behind informing them is for
5 them to help their members navigate the system.

6 CHAIR HURLBURT: Okay, thank you, Margaret, very much.
7 Dr. Lydia Bartholomew is the Senior Medical Director for the
8 Northwest for Aetna. She doesn't quite qualify for a
9 Permanent Fund Dividend, but she is up here quite a bit in
10 Alaska and as her boss, who's the Vice-President or the CEO
11 for the Northwest said when he was up here last week talking
12 with some of the state retirees, who are unhappy with some of
13 the transition things going on there, he said -- Norm said,
14 "This is the most important thing I do," and I think that
15 Lydia has exemplified that since she's come on and works
16 really hard and likes Alaska, like we all do, and has been
17 interested, so -- and she has been before several other Health
18 Care Commission meetings. So we welcome you and we appreciate
19 what you're going to -- tell a little bit about your processes
20 in Aetna for -- related to medical management.

21 DR. BARTHOLOMEW: Sure, thank you. So I guess by way of
22 background, most of you know me, but I'm a family doc. I have
23 over 25 years of clinical experience and in between that, have
24 bounced back and forth between managing multiple clinics and
25 doing payer care management and utilization work.

1 So I'm the Senior Medical Director for Patient Management
2 for the Pacific Northwest and the reason that's important is
3 because Aetna divides the work of managing care into the
4 front-end, which is the clinical patient management piece, and
5 sort of the back-end, if you will, which is claims management
6 and medical policy.

7 There are medical directors that work in patient
8 management, such as myself, and there are medical directors
9 that work in medical policy and claims management and while we
10 work together, our primary focus is different.

11 So patient management consists of the things that were
12 mentioned previously. We do precertification, utilization
13 management and care management. Both our front-end and back-
14 end activities are all based on our clinical policies. Aetna
15 has, as Dr. Grundy mentioned, nearly 900 clinical policies,
16 which are evidence-based. They are formulated on the basis of
17 evaluation of the literature, review of other state
18 guidelines, other organizations who are in the business of
19 doing evidence reviews and making guideline suggestions and
20 are reviewed on a regular basis, at least annually and
21 sometimes more frequently, depending on the situation, by sort
22 of a national group of physicians that include folks from both
23 patient management and from medical policy and a variety of
24 specialists.

25 So we select, for our precertification purposes, those

1 procedures and services that are high cost or high utilization
2 and either have very specific indications and tend to be used
3 more broadly or can -- or that we have some evidence that are
4 being overused or, in some cases, underused and those are the
5 things that we precertify and we review the precertification
6 list and change that on an annual basis depending on, you
7 know, does it appear that what we're doing has value, and
8 value would be, is there an ROI? Are we approving all of
9 them, in which case probably they don't need precertification,
10 you know, what are the other circumstances around those?

11 Utilization review goes to folks in the hospital, long-
12 term care facilities and we manage them on kind of an ongoing
13 basis to ensure that they are there and need to be there and
14 getting the care that they need and that plans are being made
15 and followed for them that are medically appropriate.

16 We have a list of care management triggers that put
17 people into care management. There are some options and
18 several different designs, depending on who the plan sponsor
19 is and how many or how few patients they would like to have in
20 case management and then for some of our folks, the nurses
21 doing utilization review and case management are the same
22 nurses. For others, they are separated again, just sort of
23 depending on the program.

24 On the back-end, we have a very extensive claims editing
25 ability. We use Claim Extends (sp), which is a very

1 sophisticated claims management software, where we can program
2 it to do different things for different plans, depending on
3 what their benefits are, different -- or different
4 circumstances and we have something like over 200,000 of these
5 claims edits and these claims edits look to see certain
6 things, like did you bill for multiple units of a service that
7 you're only supposed to do once on a single day?

8 Did you go to the ER and the facility service bill and
9 the physician bill don't match? So the physician billed a low
10 level bill, but the facility bill was higher, vice versa or
11 something like that. Are certain treatments on available for
12 certain diagnoses, and then they match up CPT codes and the
13 ICD9 codes.

14 Is there a frequency limit to something? You know,
15 should it be done once a year, once every six months,
16 whatever? It can catch all of those things. Some of those
17 things are just denied outright because there's a mismatch and
18 others of them go to one of the claims policy medical
19 directors for a medical review. Then, of course, there's the
20 fraud unit that you all heard about before.

21 The clinical policy bulletins, in addition to the
22 literature reviews and the folks who work on those, we also
23 have several condition analysis groups and those are groups of
24 physicians who are interested in a particular area. So for
25 example, there's one for women's health. There's one for

1 musculoskeletal medicine. There's another one for
2 cardiovascular medicine, and those groups of physicians,
3 excuse me, and I sit on a couple of those committees, those
4 groups of physicians look at things that they see in the
5 course of their work and look at, is there a reason to look at
6 this more carefully?

7 For example, just a small example, we noticed that there
8 were some instances where IUDs seemed to be paid for twice and
9 so the question is, you know, is that an unsuccessful IUD
10 introduction that required a second IUD to get the job done or
11 is that a missed billing situation, and we discovered that in
12 some cases, both the facility and the provider were both
13 billing for the IUD. So we were getting two bills. So we
14 were able to put some edits into our claims program to
15 automate that so that those bills only got paid once.

16 So those are sort of the general way that we manage,
17 that's like a two-minute description of a whole lot of people
18 doing a whole lot of different things, but across the both --
19 you know, before and after spectrum. So I will stop there and
20 just answer questions, because that was a lot.

21 CHAIR HURLBURT: Thank you, Lydia. Questions.

22 MS. BRODIE: All right, everybody is hungry.

23 CHAIR HURLBURT: Here's kind of a broad question, you
24 have the clinical practice guidelines that you use for your 24
25 million enrollees nationally, and you have physicians, medical

1 directors within the company that are accountable for them and
2 committees that contribute to them and they're updated
3 annually or more frequently, as you say, to what extent, then,
4 does Aetna use other materials, others doing evidence-based
5 analysis as contributing to your decisions and that may be
6 specific copyrighted products like InterQual or more general
7 resources or for example, stuff from the Technology Evaluation
8 Center from your competitors in the Blues to what extent do
9 you bring those kinds of things in?

10 DR. BARTHOLOMEW: Sorry. If you look at a list of
11 references, so our clinical policy bulletins have the clinical
12 policy bulletin and then they have all this background
13 information and then they have a huge list of references at
14 the bottom and so if you look at that reference list, we use
15 CMS guidelines.

16 We've used the Washington State Health Care Technology
17 Assessment Committee guidelines. Sometimes we're referenced,
18 you know, Blues' guidelines, as well, depending -- it all
19 depends on the situation, Cochrane (sp), you know, whatever it
20 is.

21 In addition to our own guidelines, we also use Milliman
22 guidelines for various procedures and inpatient work and we
23 also use Medicare guidelines for our Medicare patients, as
24 well.

25 COMMISSIONER URATA: So this is kind of a question that

1 might not be relevant to what we do here, but I'm curious, so
2 since we -- since the state has moved over to Aetna, I've been
3 receiving, actually in the past couple of months, letters
4 about -- inquiring about if I'd done, you know, I have a
5 patient on a Statin and so if I've done -- or they say -- it's
6 there's no evidence for a blood test to follow up on that and
7 of course, I looked it up in my EMR and I do find a blood
8 test, maybe too many, but I do find -- so I check. There's no
9 thing that says it's already been done, but what it does -- so
10 I write it in. I already did it three months ago or I put the
11 date in, but what they do have a box that says, "I'm going to
12 ignore this suggestion," or the box that says, "I will put
13 this -- I will put this into my plan, when I see the patient
14 next."

15 So number one, there should be a box that said, "I
16 already did it," and that you guys made a mistake because you
17 guys didn't see it for some reason, and maybe I didn't bill
18 you for it, maybe that was the problem, and then, 2) are you
19 using this information as a quality improvement process that I
20 may get to see, like in the past year, I did 99% correct
21 according to your guidelines or do I get graded?

22 DR. BARTHOLOMEW: At this point, you're not getting
23 graded. So those are care considerations and they're actually
24 -- they actually come from a different part of Aetna than me
25 and they look at the information that we can gather. So

1 probably you're getting those because your patients had them
2 done before we took over and we didn't get a bill for them.
3 So that would be the reason, because we do lab data based on -
4 - we get both bills and actual lab data from our vendor so
5 that we know what -- that the lab was done and what the result
6 was and other information and so I will take back that
7 suggestion. There should be a box that says you've already
8 done it, but that's where they come from.

9 That process goes through one of our other data analytic
10 engines called our Care Engine and we do use that data
11 warehouse and that information for some of our value-based
12 purchasing initiatives, so for our PCMHs and our ACOs, for
13 clinical quality measures, depending on how it's set up and
14 which ones people pick. We do follow those, but we don't
15 distribute them broadly to everybody.

16 COMMISSIONER URATA: Well, I'm wondering if that could be
17 used as a quality measure, at least for the individual
18 physicians that you're doing this to, because I'd be curious
19 to see how I grade in comparison with the rest of your
20 physicians or providers. I mean, I think that's something you
21 could use the information for and something that, you know,
22 because then, I wouldn't have to do some other stuff, because
23 it would already be done through you, at least for Aetna
24 patients.

25 DR. BARTHOLOMEW: Right, and that is what we do with our

1 PCMH and ACO models. We give practices their numbers versus
2 the market and our Aetna national averages.

3 COMMISSIONER URATA: Would you do that with our clinic?

4 DR. BARTHOLOMEW: If you would like to contract with us
5 and do a PCMH (indiscernible) model?

6 COMMISSIONER URATA: So what if we don't and -- but we
7 still get a contract with you, maybe we should put that in the
8 contract?

9 DR. BARTHOLOMEW: You know, that would be something to
10 talk about with the negotiating team, not me.

11 COMMISSIONER URATA: I mean, why (indiscernible - too far
12 from microphone) I mean, that's a possibility. You just have
13 to negotiate.

14 CHAIR HURLBURT: But you're right, you know, that's the
15 opportunity and that's the tool and then -- and Linda, who's
16 in that area, it really is focused on quality more than
17 patient and physician's practice, and you know, as a
18 conscientious physician, you'd kind of like to know, how I'm
19 on doing, on say, having a hemoglobin A1C seven or lower in my
20 Type II diabetics, and I'd like to know it compared to my
21 competitor down the street, partly that's our competitive
22 nature, but it's quality for everybody when you do that.

23 UNIDENTIFIED SPEAKER: Or the national average, because
24 you're a national company.

25 CHAIR HURLBURT: Yeah (affirmative), yeah (affirmative),

1 and which Aetna has and they have it -- their own benchmarks
2 from these 24 million people.

3 COMMISSIONER MORGAN: I'm -- I'm probably wrong. I'm
4 wrong a lot. Your company is doing this, I think, for the
5 state employees, has contracts with the state employees and
6 this is a new contract for you, I think, right?

7 DR. BARTHOLOMEW: Yes.

8 COMMISSIONER MORGAN: So at the end of a year or two, I'm
9 assuming you're going through this process because the
10 previous insurer didn't or wasn't doing something like this or
11 am I -- no, no they weren't?

12 CHAIR HURLBURT: The state procurement regulations
13 require a rebidding every so often on the contract, but Aetna
14 actually had this contract once in the distant past, but it
15 was rebid last year and there were several bidders and Aetna
16 was then picked as the successful bidder on that, but the
17 state procurement regulations require, and I don't know what
18 the periodicity is, Michele probably knows, but that it has to
19 be rebid.

20 COMMISSIONER MORGAN: So the issue, from what I'm hearing
21 is, you're going to have reports of what's being delivered and
22 it sounds like the quality, like the diabetes blood test or
23 the Statin, and then use that to actually try to manage, I
24 mean, is the information out of this to be shared -- will be
25 shared with the providers or the state and then they're going

1 to use these quality measures, or am I making a big leap here,
2 to help manage this process to improve quality and hopefully,
3 lower costs? Is that what's going on here or is this more
4 just a contract and you're trying to fulfill the contract?

5 DR. BARTHOLOMEW: I think that data has different uses
6 depending on who we're sharing it with and for what purpose.
7 So the state, I think just recently had a meeting with the
8 folks that are doing the care considerations, a quarterly
9 meeting with them and then they'll be having a quarterly
10 meeting with us coming up and then with the providers that we
11 do this, that's separate, that work and that sort of high
12 level management is separate from what we're doing with
13 provider groups, which is optional to them if they wish to do
14 such a thing with us.

15 CHAIR HURLBURT: Other questions? Deb.

16 MS. ERICKSON: Yeah (affirmative), I have a couple of
17 questions, I think for Margaret and I might have missed it,
18 but Dr. Bartholomew explained the -- a little bit about the
19 claims editing process. Is that -- how is that going to
20 improve with -- once the new MMIS is fully functional compared
21 to the old MMIS for the state Medicaid program?

22 MS. BRODIE: The new MMIS is much more sophisticated than
23 the old one. We used to be able to put a claim through,
24 actually, there was just under 900 edits and now it goes
25 through thousands of edits before it pays.

1 MS. ERICKSON: And on the medical management piece and
2 the medical bulletins that Aetna provides, and if you could
3 make the answer simple, but maybe this is another conversation
4 for another time, is what do we do in the state Medicaid
5 program to manage those sorts of questions and to provide that
6 sort of guidance to providers?

7 MS. BRODIE: To be honest, I haven't seen them. We use
8 Med as our medical evidence out of Oregon.

9 CHAIR HURLBURT: The Alaska Medicaid program is unique.
10 Most Medicaid enrollees nationwide now are in managed care,
11 where there's medical management. Alaska is the only state
12 that has never had an HMO in the state and so we don't have
13 Medicaid managed care contracts, but we -- but there's no such
14 care, other than, you know, a tiny fraction of one percent for
15 the Bill Gates' and the people like that, but really all care,
16 indemnity care, there's all medical management there to one
17 degree or another, as Lydia described, but Alaska's Medicaid
18 program, among the 50 states and the District of Columbia is
19 truly unique in that regard and the most expensive.

20 MS. ERICKSON: I was waiting for you to say that. Well,
21 I just -- I wonder if that -- how that relates to the question
22 that came up yesterday related to insurance market reform and
23 insurance laws in Alaska that might be hindering some market
24 innovation and cost savings. So maybe that's just one other
25 question to add to that list of insurance market reform.

1 CHAIR HURLBURT: Yeah (affirmative), I'm not aware that
2 the laws make a difference. I don't know if you want to share
3 what, Becky, what you and I just talked about with -- yeah
4 (affirmative), Becky, with our conversation this morning?

5 COMMISSIONER HULTBERG: You know, I don't know how -- if
6 I want to get into that right now. I just -- I think
7 conceptually, or too much but maybe at a high level, I think,
8 you know, when you look at the market, you think, "Well, right
9 now, we have different financial incentives as providers and
10 as payers," and you have a patient kind of, who's really the
11 central part of it all, but sort of sometimes in the middle
12 and there are a lot of markets, and maybe actually, Lydia
13 might be able to speak this, too, because I think this is
14 accelerating in Washington state where, you know, there are
15 really new models of organizing care where -- that are risk-
16 based, where the incentives are suddenly aligned and it's
17 suddenly in everyone's interest to do the right thing for the
18 patient, for the -- you know, in the right place at the right
19 time in the right, you know, for the right reason, not that
20 that's not happening now, but when you align the incentives,
21 suddenly things happen differently. So actually, maybe I'll
22 ask Lydia to talk about what that's looking like in other
23 markets.

24 DR. BARTHOLOMEW: Well, in Washington, there's sort of a
25 number of things that are coming together. You know, Boeing

1 is doing a direct care model where they've actually directly
2 contracted with three different systems of health care to do a
3 project where they're hoping to show decreased costs and
4 improved quality by making their members, you know, use those
5 facilities kind of exclusively.

6 I know that we at Aetna are putting together an ACO model
7 that's going to -- that includes probably four different
8 systems and patients will have, again, a narrower network.
9 They'll have to choose one of those systems to belong to.
10 They won't have to choose a PCP. They'll have to choose a
11 system and that's going to come live in July and then the
12 other payers also have their own versions of, you know, value-
13 based purchasing that are in various stages of coming up live.

14 COMMISSIONER DAVIS: So the world according to me with
15 respect to health care in Alaska, it's -- I know it's a shock,
16 but we have issues. We have structural issues, as one's who's
17 been messing around this since 1986, and there's a whole
18 variety of them, but I'll just refer to Milliman's since this
19 august body paid good money to have that study done, and they
20 found the numbers, right, that hospital cost on average, and
21 we know about averages, one actuary hits the ball 100 yards
22 right, one hits it 100 yards left and on average, they've got
23 a hole in one, so you have to be careful with that, which is -
24 - but hospitals were 27% higher on average and physicians were
25 67% higher, and the range around physicians was some

1 specialties were lower and some were 400% of the comparison
2 states.

3 So why is that? Well, Milliman identified two things
4 that are, one's in statute, one's in regulation, so I'll just
5 quote them again, they identified the regulation which
6 requires at a minimum payment of the 80% percentile of market
7 as one of the things that supports this kind of behavior.

8 There's two -- there are two, I won't say who, two
9 surgeons in town, one of them just doubled his prices and
10 since he does enough volume, his new prices will become the
11 80% percentile and the minimum required by law in a matter of
12 months. That's a problem, I think, and there's probably a lot
13 of ways around it.

14 We've talked about this before. The regulation was
15 designed to protect people who had bought insurance so that
16 the UCR was not being based on prices in Alabama. It was
17 being based on prices in Alaska.

18 Well, the market's grown up some since then and maybe
19 what we need to do is look at saying if a carrier has an
20 adequate network, then they're exempt from that because their
21 patients are already protected by the contractual agreements
22 that are in place, just an idea.

23 The other thing Milliman identified -- and that's a
24 regulation and it's under the Division of Insurance. The
25 other thing Milliman identified is a statute that requires

1 direct payment to the provider if there's assignment of
2 benefits. You can find places in the country where that
3 exists, but it's really irrelevant because in almost every
4 other market, the vast majority of providers are contracted,
5 so their contracts allow them to be paid directly at
6 contractual rates.

7 In Alaska, because of that requirement, it removes a big
8 chunk of leverage that payers could use to contract more
9 favorable terms for their people. Now, if you're a provider,
10 maybe you don't like that. If you're paying the bills, you
11 know, that you've lost a tool that's important in other
12 markets.

13 It is getting to the point where providers are willing to
14 contract for out of fee schedule, instead of a not to exceed
15 maximum of their fee for service, but that still remains a
16 barrier and Representative Keller introduced a bill last year,
17 which would have allowed, and did not pass, but it would have
18 allowed carriers to pay the member directly with a two-party
19 check if the provider was not in network.

20 That would change the market environment, because what
21 we're really dealing with is a market problem -- all playing
22 economist these days around the table, but it's supply and
23 demand. It's literally supply and demand, and Becky, correct
24 me if I'm wrong, with 26 hospitals and 23 of them are
25 monopolies.

1 Okay, so if you're a hospital in Juneau and someone comes
2 to you and says, "We want a discount from you because we're
3 going to send you more volume." When they stop laughing at
4 you, you can go out to dinner or something with them, but
5 that's just -- they have a virtual monopoly.

6 There are specialists in certain geographies who have a
7 virtual monopoly. There are groups who have an absolute
8 monopoly. That's a problem when you're trying to contract at
9 something less than 400% of the comparison states. That's a
10 real problem.

11 So I would suggest that those -- that statute and that
12 regulation need to be addressed in some way. We found that
13 the introduction of a medical travel assistance option created
14 leverage because it expanded the market into the Lower 48. I
15 will tell you the effect of that was much greater than the
16 number of people who actually took advantage of it, but it did
17 have an effect in the market.

18 There are a lot of other things, third-party payment,
19 obviously, is a problem and has, particularly in Alaska,
20 insulated people from the cost because for many, many years,
21 deductibles were not high. They were much lower here than
22 they were in other parts of the country. So we were insulated
23 upon insulated and that led providers to have the ability to
24 just raise their rates because there were no impact on the
25 person receiving the services and the law gave them the

1 ability to continue to raise their rates.

2 I could go on. I won't, but those are real issues and
3 those, to me, are the ones that really underlie, you know, so
4 you've got wellness, you've got personal responsibility,
5 you've got third-party payments that creates moral hazzard and
6 you've got these structural issues in the provider market
7 itself.

8 Without some discipline being brought to that, and I
9 don't even know what that looks like, we're going to continue
10 to be in this position where we've got the second highest
11 health care costs in the world and that's not a good place to
12 be. It doesn't mean that, I'm sorry, you know, it doesn't
13 mean that people aren't doing the absolute best they can
14 providing great medicine. That's not a part of it at all, and
15 by the way, quality, as we talked about a little bit
16 yesterday, is so difficult to chew in any meaningful,
17 measurable way, I will tell you one last story, because it's
18 my last meeting.

19 I've been doing this kind of work since 1982, in one form
20 or another, and in 1986, a colleague and I started what was
21 then called a managed care organization, because it wasn't bad
22 -- it wasn't bad language in 1986, but it was essentially a
23 reynold network and a 1-800 utilization action program and we
24 served Washington, Montana, and Alaska, which is how I got to
25 Alaska the first time and we went to this symposium and there

1 was a speaker for Kodak, if you remember that company, you
2 know, they used to make cameras and film and stuff and -- but
3 they were huge at that time and they had a health care cost
4 problem back in 1986, and so they had gone through this
5 massive study trying to figure out where there was opportunity
6 to steer their people to more efficient, more effective
7 providers and every place they went, for some reason, the data
8 broke down and they finally, like, "Aha we've found a place,
9 there's two doctors, same specialty, same town, went to the
10 same medical school and the same residency and one of them's
11 cost is three times the other one's cost. We're going after
12 them."

13 So they go to the guy whose cost is three times lower and
14 he says, "Yeah (affirmative), I'm pretty good at what I do,
15 but my really tough patients, I send them to my friend that I
16 went to school with, because he's the best," you know, and
17 that's the example that you gave yesterday, Larry.

18 So this is all really difficult. It doesn't mean stop
19 working on it, but let's do the stuff we can do. The statute
20 and the regulatory problem that Milliman described, that's
21 real. That is real and it would give -- just addressing that
22 would start to change the landscape in terms of prices. It
23 doesn't change it in terms of best practices. It doesn't
24 change it in terms of lots of other things, but at least
25 that's a positive change. So thank you for letting me be on

1 my soapbox. I'll get down now.

2 MS. ERICKSON: Can we just break for lunch? I'm going to
3 ask you a question and ask you not to answer it right now,
4 Jeff, but I want to pick your brain sometime this afternoon
5 about a third area of law and I just started paying closer
6 attention to it since a law passed this session to tweak it,
7 related to air ambulance insurance, but we also have a law on
8 the books in this state that I believe is unique in the
9 country, limiting or prohibiting HMO development and I know
10 that doesn't necessarily drive the Medicaid question about
11 whether Medicaid can do management care or not, but is that a
12 third area, again, don't answer the question now, is that a
13 third area of state law that is creating barriers to a more
14 open market function here.

15 So with that question, at the right time, we'll ask -- I
16 would like to ask Jeff, on the record, to answer, right now,
17 we are at least an hour, if not an hour and 15 minutes behind
18 schedule. So we're going to have a working lunch. We're not
19 going to break for lunch. We will break for 10 or 15 minutes
20 for Commission members to grab their lunch and come back to
21 the table so we can have our brainstorming session to -- for
22 you all to throw up on the screen through me the main learning
23 points from the fraud and abuse discussion this morning.

24 CHAIR HURLBURT: And again, for the public members here,
25 attendees, there should be plenty of lunch for everybody, if

1 you could let the Commission members go first, so we can get
2 back in session again, but there should be plenty of lunch and
3 everybody is welcome.

4 12:00:25

5 (Off record)

6 (On record)

7 12:25:

8 COMMISSIONER HURLBURT: That was part of my job to do
9 that, so thank you, and I'll reiterate that kind of do like
10 I'm doing now, get it within a couple of inches of your face,
11 so it feels a little uncomfortable, but Barb said that some of
12 the folks online had called and said they haven't been able to
13 hear everybody. So I appreciate that.

14 So we're going to have another opportunity to modify it a
15 little bit here and take advantage of Jeff, and Deb.

16 MS. ERICKSON: Yeah (affirmative), some of us were
17 talking over the break about how this -- with this being our
18 last formal opportunity to pick Jeff's brain and with his
19 decades of experience and expertise in the world of health
20 insurance, generally, and more specifically, the world of --
21 the unique world of health insurance in Alaska, if we could
22 get some closing thoughts from him before he's gone and before
23 we are all completely brain dead by the end of the afternoon
24 today.

25 So I'd like to ask Jeff two questions, maybe start in the

1 weeds a little bit more with the conversation we started
2 before the break and so the first, more specific question is,
3 understanding that the 80 percentile regulation and assignment
4 of benefits law, in your opinion, are two of the most
5 important things we could do to improve health care insurance
6 law in this state and regulation of the marketplace, what
7 other improvements do you see need to be made in Alaska's
8 insurance market regulation and in laws.

9 So that's the more specific question, how do we improve
10 state law and regulation of health insurance and the second
11 question is, what do you think the most ideal health care
12 system would look like for Alaska?

13 COMMISSIONER DAVIS: Well, thanks for the easy questions,
14 Deb. No, seriously, I appreciate being asked. I'm humbled by
15 that and again, this is the world according to me and I may
16 get some of this right and may badly blotch it, but what I
17 think we all would agree is that the definition of insanity is
18 doing the same thing over and over, and expecting a different
19 result, and the market really has not changed all that much
20 since my first footsteps on Alaskan soil in 1986, except that
21 we do have more providers and we have a much worse cost
22 problem in terms of prices than we had in 1986.

23 So you know, why is that? I think I would reiterate the
24 two -- the regulation around the 80th percentile and the pay-
25 to statute as being important things that were put in place to

1 protect physicians in Alaska, when they really needed to be
2 protected and to protect consumers in Alaska when they needed
3 to be protected because we didn't have a viable market, but
4 maybe rather than try to change those regulations, we remove
5 some things that keep Alaska unique and put it into more of
6 the mainstream in terms of what could happen and what could
7 evolve here.

8 So along those lines, as Deb and I were talking about,
9 there's two other things that stand out, kind of in the Alaska
10 regulations that -- and statute, that I think need to be
11 addressed and that's the references made earlier to the anti-
12 HMO language is that are -- that are sprinkled, literally,
13 throughout the health insurance code and this happened at a
14 time when HMOs were really out of favor.

15 I mean, HMOs are not a new idea. Dave and I were talking
16 about it, they've been -- Kaiser's been around since World War
17 II and Group Health, not long after that and there are other
18 examples, but there was a period, as you all know, where the -
19 - it moved away from the concept, which was, you know, health
20 maintenance organization was the term that was coined on an
21 airplane by a policy, health policy guru, whose name is
22 escaping me at the moment, Elwood, I think is who came up with
23 that, and the idea was that it was centered around the patient
24 and it was looking at holistically along someone's life and
25 that their financial barriers were removed so that the care

1 that was needed could be coordinated around that patient.

2 That's what staff models like Group Health Cooperative
3 and Keiser have actually done a pretty good job at doing, not
4 perfect, but when that became indemnity managed care and HMO
5 organizations and there was a lot of denial of what seemed to
6 be questionable, not denied because it was experimental, but
7 perhaps denied out of a profit motive or something else like
8 that, it became -- there became a real backlash and so
9 sprinkled through Alaska law, then, were these references to
10 things that you couldn't do.

11 Even in dental statutes, you find those, that -- and
12 those were fine for then, but we've had a number of
13 conversations around this table about payment reform, about
14 alignment of incentives, because clearly, they're not in line
15 now, right.

16 If I'm a provider, the more I do, the more I get paid and
17 that -- maybe I'm doing all the things I need to do, but
18 that's just not the right incentive. When at the same time,
19 we're taking -- we're having crowd-out in our economy. So we
20 have to figure out a way where there's a balance introduced.

21 So in order to do that, you have to, again, not continue
22 doing things the way you've been doing them, but to figure out
23 a different way to do it, but with existing Alaska statutes,
24 there's really, really limited opportunity for any kind of
25 payment reform.

1 In fact, there was a case that was just worked through
2 the Division of Insurance where there's -- what was it called,
3 not Guardian, the predecessor to that, anyway, people were
4 buying air ambulance coverage, not air (indiscernible) so they
5 were buying coverage through this entity, particularly in
6 Southeast that would be secondary coverage for air ambulance.

7 So if they had primary coverage, that would pay first and
8 then the secondary coverage would kick in. Well, what they
9 were accepting was, I think it was \$100 a year, basically a
10 capitation payment, if you will, and the way existing -- the
11 law reads is if you're accepting a payment such as that and
12 you're taking the risk for the amount of services that are
13 going to need to be provided, how many flights there are going
14 to be, you are acting as an insurer and you have to be
15 regulated under the full conditions of Chapter 20, Alaska
16 statute.

17 Okay, so what if Larry says to me, "For \$100 a month,
18 I'll take care of all of your people with this diagnosis." He
19 can't do that, and I'm not saying he would, but I'm just
20 trying -- making up an example. That might be the same thing
21 that you want to do, but it's not allowed under current law
22 and I remember, I was telling Deb distinctly, a conversation
23 in 1996 with the Division of Insurance and they said very
24 clearly at that point in time that their interpretation of the
25 regs and statute is that acceptance of anything that's not

1 fee-for-service based is a violation of the statutes and regs.

2 Well, that's pretty limiting when you're thinking about
3 payment reform. A bundled payment between a physician and
4 hospital would not be allowed under that scenario. Again, I'm
5 not suggesting that's -- but if you think through all of the
6 things we've talked about, it's moving away from fee-for-
7 service.

8 So there's some issues built into the law that need to be
9 looked at and again, if there was just one place, that would
10 be easy, but there's spattered throughout and patient
11 protection bills and other places. So it's the regulations
12 and statutes, that's where -- another place that I would look.

13 Thinking about if -- so if I were czar, health care czar
14 for Alaska and could create the system that I think would work
15 here, it would have a couple of elements to it. One is it
16 would be physician-driven, have it be physician-driven. It
17 would be physician-governed.

18 I would be centered around primary care as the middle of
19 a wheel and the other specialists on the outside of that
20 wheel. The primary care doctors would be paid in a way that
21 they could provide care that was patient-centered and
22 resourced appropriately.

23 Some of you will remember the presentation we got from
24 the doctor in North Carolina who came out and spent a day with
25 us. I'm forgetting his name at the moment, but remember how

1 they did that? They said, "Okay, we're going to form groups
2 of physicians, use primary care physicians and we're going to
3 give them behavioral health resources and pharmacy resources
4 and all those sorts of things and we're going to pay them for
5 it. We're going to identify what we're going to work on and
6 we're going to start easy and we're going to work out for
7 there."

8 That's the model, to me, is the model that would and
9 could work here. It's physician-driven. The physicians are
10 making the decisions. The physicians are given the resources
11 that they need, particularly in primary care, and resources
12 also include information.

13 If you're one of those primary care physicians, you need
14 to know that referring to Dr. Stinson cost 20% of what it
15 costs for this other outfit and that he's the highest quality
16 provider in what he does. So you would need that information.

17 There are also other things that can be done and Noah
18 Lauffer was on the Commission then and I remember he was
19 sitting next to me playing with his iPad, ironically, and I
20 was really jealous because I didn't have one at the time and
21 now, my six-year-old absconded with mine, so I don't have one
22 again, don't ever download games on your iPad for your kid,
23 it's all over. Anyway, so what was his name, Deb, can you
24 help me remember?

25 MS. ERICKSON: Dr. Dobson.

1 COMMISSIONER DAVIS: Dr. Dobson, thank you, yes, is
2 describing this model that they've built painstakingly over
3 time, one group of physicians in one geography at a time, with
4 incentives -- with agreement by the doctors, asking the
5 doctors, what is it you want to work on? What do you want to
6 improve in the patient -- and it's Medicaid, too, so it's not
7 an easy population.

8 What do you want to improve, and okay, we'll figure out
9 how to measure that and we'll pay you to do that. We'll pay
10 you in advance to do it and they turned their trend from -- to
11 negative, actually achieved a negative trend, which is unheard
12 of, right, but they did that, again, physician-led, physician-
13 controlled, resourced at primary care, appropriately, and paid
14 for differently.

15 So I kept saying to Noah, "We could do this. We can do
16 this. Why couldn't we do this here? Why couldn't we do it,"
17 and I'm persistent, if nothing else, so I kept saying it to
18 him for about two years and then finally, one day he called me
19 up and said, "Hey, we've got some ideas," and I was like,
20 "Cool." "Come over." So I went over and he said, "We're
21 going to do something like this." I said, "Great idea, Noah,
22 glad you thought of that," and I'm not making fun of him,
23 because you have to say the right things in the right way at
24 the right time to the right people and it wasn't the right
25 time and it became the right time and so it's not -- there's

1 an organization being formed with Noah and other primary care
2 docs at the head of, with Jocelyn Pimerton's (sp) great help
3 and with financial support from Premera that is trying to
4 figure out how you re-engineer the way care is delivered, not
5 how you -- in it will be the way you pay for it, too, but it's
6 not just let's negotiate down a fee.

7 It's like, okay, today, when I have a patient present
8 with possible pneumonia, I send them to -- that's the primary
9 care doc, "I send them to the ER and they get worked up for a
10 few thousand bucks and maybe they get admitted for overnight
11 observation and then they get IV antibiotics and then they get
12 sent home."

13 Well, okay, that's \$30,000. What if, instead, the
14 primary care doc says, "Just a second, I'll get the case
15 manager in here." The case manager comes in, gives them the
16 first dose of penicillin, and I'm probably getting this all
17 wrong as far as treatment, but arrange -- makes all the
18 arrangements to send this person home on IV antibiotics and to
19 be visited, you know, every 12 hours or whatever and to be
20 back in the physicians office and that costs \$3,000.

21 That's eliminating waste. Going to the ER when you don't
22 need to, is waste. Spending 30,000 when you only need to
23 spend three is waste, but it -- that's got to be physician-
24 driven. It's got to be the physician saying, "This is where
25 the opportunity is," or their payer partner is saying, "This

1 is where the pain is. How can you guys fix it," and give them
2 the resources to fix.

3 If -- that model that they're trying to develop gives me
4 hope. It gives me hope for the future, that the market here,
5 if they're successful, and I pray they're going to be
6 successful, that in re-engineering the way care is delivered
7 and the site of care that could then spread to other places.

8 If you can do that in Anchorage, you can do that in
9 Juneau. If you can do that in Juneau, you can do it in
10 Fairbanks. You could do it, you know, pretty much everywhere,
11 but there's I think where the hope lies, just doing what we've
12 been doing, praying for the day when we can have better
13 discount contracts is not really going to fix our problem.
14 We're too far gone. We really are too far gone for that to
15 happen.

16 So the good news in all of this is practically every
17 provider in town knows all the other providers in town. They
18 know who they think they can work with and who the good actors
19 are. They -- these people, as are all of you around this
20 table and in this room, are dedicated to making a difference,
21 not to be paid more, but to make a difference, to make -- to
22 eliminate waste and to improve quality, because one of the
23 leaders of this group said, "The emergency room is the most
24 dangerous place in Alaska to be because people get hurt
25 there," and that's true.

1 I mean, maybe it's not the most dangerous place, but it's
2 a dangerous place. So let's figure out how to deliver care in
3 a way that breaks the molds, that pays for things that weren't
4 paid for before, that allows for care to be -- innovation to
5 happen in -- because I bet you could give this talk and you
6 could tell me how -- what you would change in your practice if
7 you could change it and it would be -- and Larry's going to
8 have other ideas and every provider knows where there's waste
9 in the system, giving them -- empowering them to take it out
10 is how this is going to change.

11 So I am hopeful. I'm going to take some of this thinking
12 to my new city and they'll probably throw me out of town or
13 something, but I think it can be done, but it's a combination
14 of all those things and I would be remiss if I didn't mention
15 one other piece, but it fits together, and that's us taking
16 personal responsibility for our health.

17 Three-quarters of all the dollars spent are spent on
18 chronic disease. A third of chronic disease is self-inflicted
19 wounds, so I mean, not literally, but figuratively, in this
20 type of model, though, you have the opportunity to intervene
21 and to educate and to have the long-term litany of your life
22 that Noah talked about in a way that can be effective in
23 helping people get -- take responsibility.

24 You also can couple that these days and times with
25 technology, with the fact that, you know, anyone in a

1 commercial insured plan has consumer tools that -- online that
2 can help them, you know, do contests or do this or do that or
3 find information. I mean, there's just so many resources
4 available that weren't available before, but all working
5 together collaboratively, providers and patients, state
6 government removing barriers, payers getting smarter about how
7 you pay for things and provide resources at primary care, I
8 really do think can make a difference, so not a silver bullet,
9 not easy, let 1,000 flowers bloom type of situation, but it
10 can happen here.

11 We're -- our population is, what, equal to one square
12 block in Manhattan, right, I mean, come on, let's do this.
13 Let's fix this and so that's that.

14 I just thank you for the opportunity to share and again,
15 for the opportunity to be on this body and to be part of it
16 and hopefully, some of what I said might make sense. Thank
17 you. I come from a long line of preachers, you can probably
18 tell.

19 MS. ERICKSON: Does -- I have one question for Jeff and
20 then we should let people ask their questions. One additional
21 question, I'm asking lots of questions. I know, at least some
22 of the push-back that any recommendations related to insurance
23 market reform at the state level we get is that a relatively
24 small proportion of Alaskans is covered by insurance purchased
25 on the private insurance market, which is the only insurance

1 that's government by state rules.

2 So how would you respond to that? How does that 15% of
3 the population, or if that's what it is, covered by the
4 private insurance, how might -- one, how might that be
5 changing and how might that drive the entire health care
6 system?

7 COMMISSIONER DAVIS: Sure, that's a great question, Deb.
8 So what Deb's referring to is that states regulate insurance.
9 They don't regulate self-funded plans. That's done under
10 federal control through ERISA. So any state law that falls in
11 the category of Chapter 21, right, 21 not 20, is going to
12 apply only to about the 15% of the population that is covered
13 under insurance.

14 However, as Becky and I were talking about at the break,
15 that sort of sets -- that sets the bar, okay. So if you have
16 an 80th percentile regulation, that's the bar for -- that's
17 been set by the state and if a self-funded employer wants to
18 pay something -- on some different basis, they now have become
19 the outlier in the market and it's difficult, as an employer,
20 to make those sorts of decisions and to back them up.

21 Whereas, I think if, you guys are laughing, right, it's
22 really hard, especially with a non-diminishment clause in the
23 constitution, wow, what a mess. If that barrier were removed
24 and it became a market standard that Aetna and Premera and
25 whomever else adopted to use some other methodology, I think

1 the self-funded employers, most of them, would follow suit.

2 So even though it doesn't apply legally, in all practical
3 senses, it does. I know that there are discussions going on
4 in the community right now that I'm not a part of are -- is
5 really going to some self-funded clients and saying, "Are you
6 willing -- would you be willing to take this step," but I
7 don't -- I haven't heard what the conversations coming back
8 is, but I'm guessing it's, "We don't want to be the first one
9 off the cliff," and that's where they would be now.

10 MS. ERICKSON: Other questions for Jeff?

11 COMMISSIONER DAVIS: I'm not even on the agenda.

12 COMMISSIONER URATA: This is your last meeting, so we
13 want to make sure you don't forget about us. So you know, I
14 think the 80% rule, if we try to change that, would have push-
15 back, but what -- how would you respond to the physicians that
16 this rule is not needed and what would you do to replace it so
17 there's no unintended consequences of insurances low-balling
18 the physicians?

19 COMMISSIONER DAVIS: Well, I would first point to
20 Milliman and I'd say, "This is not a problem across
21 specialties. This is not a problem in primary care. This is
22 not a problem in a number of specialities, but where it is a
23 problem is where market power is concentrated, either from
24 geographically or by a specialty," and so then I'd start to
25 say, "Well, how do you answer that," and model 50 different

1 scenarios and they all have unintended consequences, but then,
2 one of my colleagues came up with what I think is brilliant
3 and that is this idea that I threw out earlier of using -- the
4 state already has network adequacy rules.

5 In fact, CMS certified that the state's network adequacy
6 review was adequate. So what if the regs said, "80th
7 percentile market, lah, lah, unless you meet network adequacy
8 requirements as defined by the state," again, just bear with
9 me for a second, I'm going to repeat myself.

10 That reg was put in place because we had a broken market.
11 We didn't have supply and demand that was resulting in
12 contracts being written that physicians had agreed to okay, so
13 and the -- rushed into that vacuum was payers who were paying
14 at Alabama rates, okay, and then a patient being stuck with
15 the bill.

16 The world has marched on, though, in the last 20 years,
17 and in fact, some entities are having some pretty good success
18 negotiating with providers and building an adequate network.
19 In the Lower 48, it's all based on an adequate network, you
20 know, the same rule applies. You have to have an adequate
21 network. If you do, then you have got financial terms in
22 place that are the ones that you and the providers have agreed
23 to and there's not another artificial standard layered over
24 the top of it.

25 You can create anything you want, but here, it's like

1 rather than trying to change the rule so that it works in
2 Alaska, let's change the rule so that Alaska's like the rest
3 of the country and using a network adequacy standard would do
4 that and it would also -- it would force carriers who haven't
5 had to put any or little energy into their networks to say,
6 "That's a barrier to entry now that we need to overcome. We
7 need to work on that."

8 It would turn the market forces loose that aren't there
9 now. So yeah (affirmative), that's -- I think there's a lot
10 of merit to that because otherwise, there are winners and
11 losers. I mean, I came up with this cockamamie scheme that
12 would say, "You freeze UCR at whatever it is today and it can
13 rise no more than the overall, you know, inflation in the
14 market for any one code until the day when the newly
15 calculated UCR equals the one that was frozen." That's just
16 complicated, so -- and you're going to get -- people don't
17 know how to do math, I mean, they don't even understand
18 percentage, rather than -- not even versus percentile, so it
19 just gets so complicated so quickly that in a public -- well,
20 that's actually a regulation, so -- but imagine the Governor
21 having to try to defend that. I mean, it's just tough, but
22 that's what I'd do, Bob.

23 CHAIR HURLBURT: Any other questions? David.

24 COMMISSIONER MORGAN: I -- this is kind of a combination,
25 this -- have you ever been or will you be a member -- I'm

1 sorry -- no, okay, I have a small preface, after we had that
2 discussion by Dr. Dobbs I happened to be in the Carolinas that
3 summer, so I spent a (indiscernible) holiday for a day and
4 everything you've described and more was involved in that
5 system and it was all good.

6 What I particularly liked when I went -- he took me over
7 to show one of the first groupings and they had -- they have a
8 system set up where a doc, not only can sign up to do the case
9 management you were describing, but they got a small stipend
10 for doing it, but they automatically had access to like HEDIS
11 measures and would report them.

12 They would all kind of agree to that as part of the
13 metric and if they had a diabetic that they wanted to get into
14 a certified diabetes education nutrition program, they could
15 hit the button and it would show all the five that were
16 certified in their catchment area with their prices and
17 backgrounds to make a referral.

18 Basically, any doc, primary care doc that joins the
19 network you described is a medical home, even if it's only a
20 one-person practice and I was looking at that and I found it
21 very amazing. Now, would -- are insurance companies, now that
22 you're leaving, I think you can say because I'm asking
23 generically, are insurance companies that are operating in
24 Alaska now, receptive to that of negotiating, if they could,
25 negotiating, working with these networks, which there could be

1 many. There could be some small ones. There could be some
2 big ones, but it basically fit around a physician or groups of
3 physicians that wanted to align themselves.

4 I mean, they had one that was just diabetes and then they
5 had a bunch of general practitioners, if you remember, but
6 what's -- are the insurance companies nimble enough, you
7 think, or would the market forces bring them to, you know,
8 bring the horse to the water to do it?

9 COMMISSIONER DAVIS: Yes, some of them. I'll reference
10 the discussion with Noah, it's been going on for a long time,
11 but Jocelyn Pimerton told me yesterday, they're really close
12 to finalizing a contract. I mean, one of our meetings was on
13 Mother's Day at Noah's house. My wife was happy about that.

14 Anyway, so this stuff takes time. It's not -- it's not
15 fast and because you're, partly, you're dealing with
16 physicians who are physicians right, not network professionals
17 or business professionals and so you have to build confidence
18 and kind of take it at the pace that it will come together,
19 but Premera is there at the table and willing and getting
20 ready to write a check, I believe, to help support the
21 development of this organization because of our scope and size
22 in Alaska.

23 Okay, there's -- it makes sense to dedicate the
24 resources. I think Aetna has that same scope and I know
25 they're experimenting in many things all over the country, as

1 is Premera in Washington. We've got 100,000 people or more in
2 clinics that are not being paid -- that are being paid on a
3 risk-based, you know, it's complicated. They're being paid a
4 base with their raise the next year dependant on the
5 innovation they do around re-engineering care and taking care
6 of their people better than the market. So that's pretty
7 innovative.

8 We couldn't do it here right now with existing law. So I
9 think the answer is yes. It's in no one's best interest for
10 Alaska to have the second highest health care cost in the
11 world. I'm not going to say, "No one," there might be some --
12 well, I won't go down that road. So it's not in our client's
13 -- any carrier's best interest, because it's not in their
14 client's best interest and so everyone is looking to figure
15 out how to crack the nut and I won't repeat what I said
16 earlier, but I described to you what I think cracking the nut
17 looks like and it wasn't built on All-Payer Claims Databases.
18 It's not built on any of that stuff. It's built on physicians
19 in control of the information they need, deciding -- spotting
20 the waste, going after the pain and being rewarded for doing
21 so. That's better for everybody.

22 COMMISSIONER HULTBERG: I'm not sure why -- I just -- I
23 just wanted to point out, I think that it's, you know, it's
24 really a good conversation to have that I've fallen into the
25 trap and I think we need to, you know, that it's good to

1 remind ourselves that we have urban areas where care looks a
2 certain way and then we have rural areas where care is very
3 different and these are good conversations because they're
4 going beyond rates and discounts, which I'm not sure, you
5 know, just talking rates and discounts, whether it's Medicaid
6 or commercial insurance, is going to really be a productive
7 way to get us where we need to be. So these kinds of
8 conversations are really good.

9 We -- in those conversations, though, I just think we
10 need to recognize that the market in Anchorage is very
11 different than the market in Wrangle and we need to be really
12 careful that as -- that we're recognizing the differences in
13 our state and that we're protecting access to care in all of
14 those places, because in some ways, while health care may look
15 expensive in rural areas, it's -- if you can provide it in the
16 right way, you're preventing the Medivac, which is really
17 expensive and so just recognizing those regional differences,
18 I think, is an important part of our thought process as we
19 consider these types of issues.

20 COMMISSIONER DAVIS: I agree and that's exactly what they
21 did in North Carolina. They formed, I think it was 11
22 different regional organizations. So if you follow that
23 model, you'd have a regional organization in Wrangle and
24 Petersburg, I'm just making it up, and it would be physician-
25 driven, physician-governed, and they'd say, "Here are our

1 issues. Here's the things that are causing the Medivac.
2 Here's what we don't have that we need," and so it's not -- it
3 certainly is not a one size fits all, but if you follow those
4 principles of physician-driven and governed and controlled and
5 paying for the outcomes, you're going to get to the right
6 solution in each one of those, but it requires being open to a
7 whole bunch of things that haven't fit before.

8 I think, you know, rates and benefits, you're absolutely
9 right, are not going to get us where we want to go. They're
10 table stakes. You've got to -- you've got to do that and
11 that's not going to get us where we need to go. It's not
12 going to meet the goals of this Commission to have Alaska be
13 the highest -- healthiest and have the lowest cost. You're
14 not going to get there with rates and benefits. It's got to
15 be re-engineering what doesn't work.

16 CHAIR HURLBURT: Yeah (affirmative), I think that one of
17 my concerns with Jeff leaving was what would happen to the
18 efforts that Jeff has been leading, working with a group of
19 primary care physicians in Anchorage and the feedback I get,
20 at least so far, it feels like Premera's committed and engaged
21 and will continue, and I hope it will, and it took some key
22 docs, like Noah or like Jeremy Gitomer, who have pretty good
23 business sense, but then when you look around the state and
24 where most of the people are, not to embarrass you, but I, you
25 know, in your (indiscernible) days, I knew you as a solid

1 clinician and by reputation, but when I was out begging to
2 have you get in Aetna's network, I was impressed what a good
3 business person you are, so -- so -- but as a positive thing,
4 but I think, you know, when you look at Juneau, you've got a
5 good size, a big group for Juneau, really, there that's highly
6 respected in town, and you know, you have physician kind of
7 skills, but business kind of skills that can do it there .

8 If you look at Fairbanks, you know, certainly elsewhere
9 in the country, Banner Health engages in those kinds of
10 relationships and they have the medical group there, as well
11 as the hospital. So you know, I think there's the potential
12 for moving in maybe a chunking kind of way of getting there.
13 Jim, yeah (affirmative).

14 MR. PUCKETT: I just have a quick question for -- I'll
15 wait until you're done eating. No, this information that
16 you're sharing about these groups that predates when I came
17 onto the Commission. So my question is, the 11 regional
18 groups that they formed in North Carolina, I'm assuming that
19 the locality or the region that they were going to be serving,
20 there was -- they were the ones that pretty much set it up the
21 way they wanted it set up, so they're not -- I mean, I know
22 there's some redundancies here, but they -- it's pretty much
23 set up by the local folks?

24 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
25 microphone).

1 MR. PUCKETT: Okay, and then the other question I have
2 then is, can you steer me to the information about this from
3 the past?

4 MS. ERICKSON: We, actually, webinared that session and
5 have a recording of the webinar on our -- and it was an
6 excellent presentation and so you can see the slides and hear
7 Dr. Hobson's voice over it. So I will send that link out to
8 the group, to the full group, because half of you probably
9 weren't here at the time. That was a good two or three years
10 ago. So I will do that. I lost Barb. I'll make a note real
11 quick. Somebody else ask Jeff a question while I go write on
12 my to-do list.

13 COMMISSIONER MORGAN: They will -- what I like when I --
14 I did my little one day visit, what I liked about it was what
15 he described -- it's now, I think they actually have a 12th,
16 when I was -- they have some of the same stuff here. They
17 have -- the western part of the state is sort of isolated in
18 the mountains, has a different -- different problems, that
19 group, but also the groups kind of have -- the 12th one is
20 more -- there are problem-specific like diabetes and asthma
21 kind of stuff, but it's very fluid and all the physicians work
22 together.

23 The districts are more like primary care type of stuff
24 and well-babies and babies and have home health and they kind
25 of work that. The Legislature, actually, had to go in and do

1 some of the things you described legislative-wise in order to
2 overcome certain regulatory issues like they had the same
3 problem where a lot of things -- to keep out the evil HMOs
4 were put in that kind of kept these groups from forming from a
5 competitive stance.

6 My first job out of the Army in the early '80's was for a
7 staff (indiscernible) HMO that was started in 1905. The first
8 HMOs were nonprofits and usually granges. I know that's -- a
9 lot of people may not -- unless you're from the midwest or the
10 southeast, agricultural communities that couldn't get a doc,
11 so everybody chipped in three bucks on their grange bill where
12 they bought grain and grain storage or whatever the
13 agricultural community to hire a doc.

14 They had a fee schedule, a little fee schedule and
15 usually had a small three or four-bed hospital at the turn of
16 the century. It didn't get evil until they started getting
17 into the stuff he was talking about, denying, we're not going
18 to pay for that -- you went outside the network, therefore,
19 you're on your own kind of stuff, but it sort of reminded me
20 of that.

21 The United Mine Workers used to have a program and it's
22 still in some places alive, where they had visiting nurses
23 that would go up to the coal camps and it kind of reminds me
24 of the CHAP program and also what he's describing. So the --
25 I think he's right. I think Jeff -- that's why I really hate

1 to see Jeff go because this might be the other track of the
2 rail -- of the train rails to get us to where we kind of want
3 to go, but it will take some legislative action, I think,
4 right, is that -- have I -- right?

5 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
6 microphone).

7 CHAIR HURLBURT: Anybody else?

8 COMMISSIONER MORGAN: I delayed it as long as I could.

9 MS. ERICKSON: I think we're ready to move on, but thank
10 you very, very much, Jeff. We really appreciate it. I'm
11 going to do a quick time and process check. I believe, Emily
12 and Lisa, I'm talking to our speakers in the room, I had
13 suggested that you'd probably start at 1:30, asked you to be
14 ready as early as 1:00. I think we're looking at probably
15 between 1:30 and 2:00. Does that work okay for you to start?
16 We'll try to start right at 1:30, but we're about two hours
17 behind our schedule right now.

18 UNIDENTIFIED SPEAKER: That's not a problem.

19 MS. ERICKSON: We ate lunch. We're only an hour behind
20 still. So we're going to take this next half-hour, we
21 actually already did one of the two first bullets we were
22 going to do before Healthy Alaskans yesterday, learning about
23 the Health and Health Care in Alaska 2014 Project and I will
24 just refer you all to the work plan for the Commission that is
25 behind Tab Five.

1 I had thought, at one point, that we'd go over that
2 together, but we're not going to do that today. You don't
3 even need to look at it right now, if you don't want to, but I
4 would ask that you look at it at some point and let me know if
5 you have any questions or comments or suggestions about our
6 plans for the rest of the year.

7 So we'll be ready when we're done with our fraud and
8 abuse discussion to go straight into our Healthy Alaskans 2020
9 update, but I want to go back to the conversation that we
10 continued with Andrew and Doug, especially this morning,
11 following up on the March conversation around fraud and abuse
12 and opportunities for improving, strengthening, and
13 streamlining the Medicaid fraud control programs and just see
14 if we can capture some of your thoughts.

15 I -- if you could look back at the preliminary thoughts
16 that we caught from you after the presentations in March that
17 you have in your notes -- in your notebook and again, one of
18 the extra handouts I gave you, it was both behind Tab Four in
19 your notebooks that you received a couple of weeks ago, but
20 then I gave you a one-pager with that this morning, too, so
21 you have that handy, but I just want to start.

22 We'll do the kind of stream of consciousness open
23 brainstorming and see how that works as a starting point for
24 capturing some of your thoughts about where and how you think
25 we could make recommendations for improvement and also, if you

1 want to make any suggestions about what you think just a major
2 learning point from this morning was, too.

3 COMMISSIONER URATA: So they had some statutory changes.
4 Did you capture those, Senator?

5 CHAIR HURLBURT: I think that probably it would be
6 helpful to make sure we've captured them. I suspect they've
7 got them all, but we may want to coordinate because I think it
8 would probably be helpful to Senator Coghill and to others who
9 are interested to have input from.....

10 COMMISSIONER URATA: Okay, well, I was just wanting to
11 say that the RAC audits, I'm happy to hear that they might not
12 exist anymore because I feel that they are more interested in
13 collecting their fees, rather than really finding the truth,
14 but -- so I think that's good, but I do feel that working on
15 fraud and abuse is an important part of what we do.

16 MS. ERICKSON: Can I just -- I'm going to interrupt the
17 brainstorming. I don't want to read too much into what you
18 said and one of the things they brought up was a possibility
19 of actually asking the federal government for a waiver from
20 that Affordable Care Act provision. So I'm not reading too
21 much into your statement to add that? Okay, thanks.

22 COMMISSIONER URATA: It's just uncomfortable as a
23 physician to have a RAC audit when, you know, and I think
24 we've had two of them and they haven't found anything in our,
25 at least in our clinic.

1 UNIDENTIFIED SPEAKER: They did it for nothing.

2 COMMISSIONER URATA: Yeah (affirmative), so they -- so
3 they were there for nothing and I mean, and that's what we
4 strive to do is we strive to be honest in our clinic and
5 follow all the rules that we know about.

6 COMMISSIONER HULTBERG: There's a whole body of
7 information that if this group was interested, I could link
8 you to on the RAC audit issue, as well. It's not just the
9 physician side, it's the hospitals are having really negative
10 experiences with the program as well.

11 CHAIR HURLBURT: On the prescription drug management
12 program where two or three years ago, we lost the federal
13 funding as other things became priority with the federal
14 government, I guess one thing will be to monitor what happens
15 with them -- with the White House Office of Drug Policy and
16 see -- you see it becoming more interested .

17 It's possible there could be a restoration of more
18 federal money and cranking out the printing presses for more
19 money that they don't have, but I think within the state, that
20 to expand to a more robust program without the limitations
21 that Larry described will cost us more money and that still
22 could be a wise thing to do.

23 Washington, I know, believes they've saved significant
24 lives through their program, but even in the absence of that,
25 from what Margaret said and what I commented yesterday that

1 the (indiscernible) pharmacist told me, it would seem like
2 that we may want to consider a recommendation to change the
3 legislation to allow the Medicaid program and the Medicaid
4 pharmacist to have access to the prescription drug management
5 program information on Medicaid enrollees, that it sounds
6 unusual.

7 MS. ERICKSON: And should we include the Department of
8 Law, since right now, they would need to get a warrant?

9 CHAIR HURLBURT: Yes.

10 COMMISSIONER DAVIS: I'm just curious, does anybody know
11 why we ended up with that stipulation?

12 MS. ERICKSON: My -- this is just what I.....

13 COMMISSIONER STINSON: Privacy advocates, privacy
14 advocates.

15 MS. ERICKSON: Privacy advocates and there was a focus on
16 criminal issues and not these other opportunities, I think,
17 was my understanding.

18 COMMISSIONER HIPPLER: There was a discussion about PSAs
19 and no background checks that are currently required, is that
20 correct or PCAs?

21 COMMISSIONER MORGAN: I think the issue was, to sum this
22 up quickly, is we have groups of providers, provider
23 groupings. Under the old system, before the new Xerox MMIS
24 system, you'd enroll for a chore or transportation and some
25 areas in behavioral CHAPS, the PCA program and they would then

1 have one number and an agency doing this, but they could have
2 25 people doing it.

3 They were obligated to do those things, get the
4 background check, have this, have that, you know, certain of
5 these categories would CHAPs have to go to the CHAPs school,
6 you know, they all had different things, but the agency that
7 was employing them and billing via that number were obligated
8 to make sure that happened.

9 Medicaid or other programs, then, if they thought there
10 was an issue, would come in and say, "We're here to review
11 your CHAPs or your PCAs or whatever." They'd pull a certain
12 number of files or all of them, look in there, look at their
13 billing and follow through.

14 I think in order to detect what I call shenanigans under
15 the new system, and I wish she was still here, she probably
16 could explain this better, we actually enroll all those people
17 under that number, not as detailed as a physician, but with
18 the general stuff they're supposed to have, but more
19 important, you get a rendering provider and you have to have a
20 checkmark and say you got the background check, if that's
21 what's required.

22 I think that was a problem. They had our fraud and abuse
23 unit couldn't -- it was tough to get at that. Under the new
24 system, the way I got it, is that's the way it's going to
25 work, but they haven't completed getting all these new people,

1 individuals set up in the end.

2 I know they did the personal care attendants under that
3 program and we went from 8,000 enrolled rendering providers to
4 18,000. So when you start adding all these others, it's going
5 to be -- it's going to take them a while. I think if they --
6 the more resources they had, they probably could do it quick,
7 so that's -- but that's an operational issue, I would think
8 that Commissioner Streur and his crew would deal with, but as
9 someone's that's involved with that and has been, there will
10 be push-back, guys.

11 Nobody likes more paperwork, but I've been trying to
12 jawbone as much as I can, simply because it makes us look bad
13 when that -- those -- when that 3% pull something or doesn't
14 do what they're supposed to do and we have a problem and then
15 we've got to go and ask the senator and the congressman or
16 even Commissioner Streur for more money or more programs, at
17 the same time that some things kind of detonate and we've got
18 a problem.

19 I think we -- I think from an audit standpoint, I think
20 that's what they were talking about and that's -- it's already
21 started being -- that's already being filled. Now, I --
22 they're probably -- you have it -- behavioral health, so you
23 probably -- I don't know about that part of it.

24 MS. ERICKSON: Go ahead, Emily.

25 COMMISSIONER ENNIS: There are -- there have been

1 responsibilities at agencies for years to make sure no
2 employee begins work until they complete the background check,
3 fingerprinting and all of that and get a provisional approval
4 that they can begin work.

5 So the burden of that, you know, completing those
6 requirements have been on agencies, small or large, and I
7 think one of the concerns is in the field of personal care
8 attendants, home and community-based providers, there's high
9 turnover and so in order to keep services going to meet the
10 needs of individuals who are living, you know, pretty much on
11 their own in communities, you know, agencies just have to keep
12 those new employees rolling in and I -- it's not an excuse,
13 but they have to be on top of making sure that all the
14 requirements are met for those employees before they send them
15 out to provide that service, but it is an extremely burdensome
16 and administrative responsibility that organizations have to
17 accept as part of doing this work of making sure that the
18 employees they do hire and send out, meet those requirements
19 for many, many reasons.

20 I think this is a big concern, not just for background
21 check and all, but the training that's required, the CPR,
22 first aid, all -- you know, there's a number of things that
23 each of those individuals who generally come without training
24 must comply with before they provide those services.

25 We need to remember that this is a large workforce now

1 that's providing home care and not an institutional setting.
2 It's cost effective, you know, it's certainly critical because
3 we don't have adequate long-term care facilities, whether it's
4 assisted living or other options right now, particularly for
5 our elderly, who are needing these more and more often.

6 So we've got to find a way to address the needs of this
7 particular workforce in Alaska and you have to remember, they
8 are assigned an individual person. They're sent out to the
9 home. They're not supervised. You know, there's a great deal
10 of faith in the 8,000 -- 800,000 employees, I mean the number
11 is extraordinary and it growing.

12 PCA services are just one of these many options that are
13 available, chore services that help a senior get to pick up
14 their medications, go to the grocery store, helping them write
15 a check to do this. I mean, the exposure is extreme in terms
16 of a liability. So respite care, again, you're in a home with
17 someone who really can't -- is not a good historian. You
18 don't know if -- they can't tell you that provider showed up
19 at 2:00 and stayed until 4:00. I mean, you're trusting the
20 individual to fill out a report, yes, and of course you hope
21 you've done a good reference check and you have a qualified
22 trustworthy employee, but with that number that we are now
23 seeing in Alaska and growing, there's a great risk you -- and
24 also, I can't emphasize enough how important it is to have
25 that qualified warm body to show up on time for an individual

1 who was needing that individual to help them get out of bed in
2 the morning.

3 So you know, there's this push from all sides to get the
4 right individual with the right background check proved and
5 training and keep the system going. We need to, as a state,
6 figure out what technology, what support and unfortunately,
7 some extra reimbursement to agencies and individuals that are
8 hiring and overseeing this growing workforce.

9 I mean, one of the things, you know, we're looking at as
10 an expensive investment, but handheld GPS devices that our
11 providers take with them. So at least we know they are where
12 they say they are when they said they were going to be there
13 and they're going to leave that home at a certain time, that
14 you know, they were assigned to for three hours, six hours,
15 whatever it is.

16 I mean, it's just one method, but you know, you think it
17 might be overkill, but you know, you have the possibility of
18 fraud that exists when that provider says, "I'm -- I did
19 provide that service." They turn in their report and said, "I
20 spent four hours with Mrs. Smith. I helped give her
21 medications. I helped her with her bathing," and we, you
22 know, we have to accept that report as the billing document
23 that, you know, then we get reimbursed for through Medicaid.

24 We need more checks and balances and as a state, we need
25 to invest in those. I mean, providers need to figure out how

1 to do that, what's going to work best for each and every one,
2 but we have to have some additional checks and balances.
3 Background checks are just the beginning of that process.

4 COMMISSIONER MORGAN: But our guy from the guys that were
5 doing the fraud and abuse, the system is set up so that we can
6 -- they can, at least, know all the rendering providers.
7 There was this -- it's kind of tough on them to at least have
8 that check on the other side in order to do and to make sure
9 that there's not fraud and abuse. For them to find -- it's
10 like in travel, remember they were talking about, they get the
11 rendering. They finally found a rendering because there was
12 some weirdness going on and checked with INS and they were
13 actually in Mexico.

14 So at least from an audit standpoint from their -- from a
15 fraud and abuse standpoint, the system has now been changed,
16 so all the rendering individuals will be in there and it makes
17 it a little easier to catch some of this stuff, but it does
18 mean we're going to have to do some more stuff.

19 MS. ERICKSON: Senator Coghill.

20 SENATOR COGHILL: The statutory changes that I heard were
21 on some providers since the risk is a little higher is the
22 ability to require bonding and forfeiture, which will be not
23 an easy discussion, but it's also true that, as Emily said,
24 that risk is high and I think they need to have some coverage
25 from that risk. So bonding may be part of the answer.

1 The other thing is, and I don't know that it's a
2 statutory change, but it would be interesting to find out if
3 there's any statutory barriers and that is in the
4 collaboration area between the Department of Law and their
5 ability to work with our Medicaid services in being proactive.

6 There's probably a liability question there on if they
7 are working with providers in proactive way trying to keep
8 them from error rates and I don't know how that will work, but
9 that's a question that came up in my mind is, are there
10 barriers and is there something that they've already got
11 working on and that's probably further looking into it, I
12 mean.....

13 MS. ERICKSON: Other ideas that folks picked up on this
14 morning? Well, so hearing none, I did take lots of notes this
15 morning. What I will do is pull, incorporate the notes into
16 the discussion notes from March and the slide that I just
17 captured now and what I'm going to do is circulate it to you
18 all over email and try to get some feedback that way and see
19 if we can refine it between now -- instead of spending more
20 time working on the details and wordsmithing in future
21 meetings . Does that sound like a good plan? Any final
22 questions or comments related to fraud and abuse control
23 before we move onto our next topic?

24 Very good. Well, I think we're ready for our update on
25 Healthy Alaskans 2020, and while Lisa and Emily come up to the

1 table, I need to get their presentation opened and I don't --
2 we -- you know, we might have a couple of new people around
3 the table since, Lisa, you and Emily's predecessor on this
4 project, Bev, last reported to this group, but -- so just by
5 way of introduction for Healthy Alaskans, a reminder that kind
6 of the top bubble in the diagram of our vision is healthy
7 Alaskans and that Alaska will have the healthiest population
8 in the country.

9 We have been concerned enough, for good reason, about
10 health care costs and quality as, at least, the cost piece at
11 a crisis point that requires significant attention that we
12 have, essentially, after visiting at one point, some top
13 priorities for population-based prevention, have kind of
14 turned over the -- any responsibility related to population
15 health improvement to the Healthy Alaskans initiative where
16 both, the state Division of Public Health, Department of
17 Health and Social Services has been partnering over the past
18 couple of years now with the Alaska Native Tribal Health
19 Consortium on a statewide effort to first, identify the
20 leading health indicators for the state.

21 There was a real involved process to identify those and
22 now they're in a process to actually move that forward and
23 look at strategies for improvement and so we haven't heard
24 from them for a while, but consider them real important
25 partners of the Health Care Commission and so I thought it was

1 important for them to update you all on that piece right now.
2 So Lisa, and I'll just let you both -- Lisa, reintroduce
3 yourself and Emily, introduce yourself to the group.

4 MS. AQUINO: Sure. Hi, everyone, I'm Lisa Aquino and I'm
5 with the state Division of Public Health. I'm the Community
6 Health Improvement Manager, and yes, previously, I was joined
7 here with Beverly Wooley from the Alaska Native Tribal Health
8 Consortium, but I'm very happy to have Emily Read here with me
9 and I'll let Emily take it away.

10 MS. READ: Hi, I'm Emily Read. I'm with ANTHC with the
11 Division of Community Health Services and we joked for several
12 weeks about the large shoes that I was filling, so Beverly is
13 always on her cell phone for me, so yeah (affirmative), I
14 appreciate the opportunity to be here, but yeah (affirmative),
15 Beverly has retired with a capital R, I believe this time. So
16 I think it's for real, yeah (affirmative).

17 So would you like me to go ahead and get started? So
18 thank you very much for allowing us to be here and give you an
19 update today. Like I said, I'm with the Alaska Native Tribal
20 Health Consortium and this is a very powerful and unique
21 collaboration that we've established between the Alaska
22 Department of Public Health and ANTHC.

23 So we see a lot of benefits to this work. It is actually
24 the first time that we know of where a state -- a state and a
25 tribal entity have come together to evaluate and assess the

1 needs for health improvement and excuse me, the health needs
2 and establish leading health indicators, which we've done.

3 So there are many benefits, like I said. We believe we
4 have increased stakeholder participation, greater diversity,
5 as well as, I think, we just have a much better sound grasp on
6 the health needs of Alaskans.

7 So our steering team represents the highest commitment,
8 highest level of commitment to the vision. Uh-oh we're back,
9 there you go. That's the vision of Healthy Alaskans 2020
10 right there. So we have -- we represent a very high level
11 commitment to this vision and to this mission. Next slide.

12 MS. AQUINO: Hi, so we're going to kind of switch back
13 and forth, casual style. So as you saw in our last slide,
14 what we really feel our role is, is to development this
15 framework for health improvement in Alaska and this framework
16 is a place to come together.

17 It guides efforts in our state over the decade to improve
18 the population's health and ensure health equity for all
19 Alaskans and as Deb mentioned, you know, we partner really
20 closely with the Health Care Commission and we work really
21 closely with Deb. She's on our advisory team and we are in
22 the draft plan, in the plan you put forward, really speaking
23 to the population health priority.

24 So -- so -- but it's a big -- it's a really big thing and
25 so what we, as Healthy Alaskans 2020, want to do is really

1 create this framework that everybody can come together and
2 work within together, so -- and just to say about the
3 framework, so it's a place where -- because these health goals
4 that we have, the 25 leading health indicators that you have
5 in front of you, they are enormous, complex goals and we're
6 not going -- there's no one agency that can reach those by
7 themselves.

8 It's not going to be possible for just the state of
9 Alaska, Division of Public Health or the whole department by
10 ourselves to reach those goals. It's not possible for ANTHC
11 alone to reach them. So we really need to have a framework
12 where all of our partners together can come in and work
13 together. We can all be there together, going toward the same
14 goals, being accountable to each other and so that's what
15 we're trying to do with Healthy Alaskans is really have that
16 framework and how we -- and so I'm going to describe it a
17 little bit.

18 So there's really just three parts of it. There's this
19 idea of a shared understanding. So the first thing we had to
20 do is to build a shared understanding so that we -- all of our
21 partners in this effort, we have the same understanding of
22 what the problems are because we are all coming from different
23 places and then also, a shared understanding of what the
24 solutions should be, looking at the evidence-based, looking at
25 the science and also looking at what's happening in our state.

1 So that's the first part of our framework.

2 Then the second part is this idea of united efforts and
3 that speaks again to what I was saying originally about how
4 this isn't going to happen, unless we can all come together
5 and work on -- and be united and work together to make this
6 happen and then finally, the last piece is this idea of
7 collective accountability, and you know, that might sound a
8 little bit jargony, but it's really critical. It's so
9 important.

10 We have to break down the silos and I know everyone
11 always says that and we say it again and again and again, and
12 it doesn't happen, but I really hope that this framework can
13 be a place where that can happen, an instance where that is
14 happening, because we have to be accountable to each other,
15 partners at the table.

16 We have to be willing to put the work that we're doing
17 together at the table and if it's not working, listen to each
18 other as partners, say, "You know, I see your numbers coming
19 back. It's not working. Let's stop doing that," or if
20 something's really working, "Hey, I see that's working. I'm
21 not competing against you. We both want to reduce obesity in
22 this state. Let's work on this together, if this is something
23 that works." So this is the framework we've put together as a
24 part of Healthy Alaskans 2020.

25 Yeah (affirmative), let's go to the next one. So this

1 very busy and colorful slide is -- these are our deliverables.
2 There are our deliverables that we're working on now in this
3 current fiscal year and we're on the federal fiscal year, and
4 I'll talk a little bit about why in just a minute, but these
5 are the deliverables we're working toward.

6 So we, as Deb mentioned, we've spent, really the first
7 year of our project assessing health in the state and that
8 involved looking at the data that was available, as well as
9 talking to Alaskans about what were health priorities to them
10 in their communities and then working with our advisory team
11 and the public, well, mostly our advisory team, to prioritize
12 25 leading health indicators.

13 So now, moving forward, these are the three deliverables
14 we want to -- we need to finish. One is this idea of ongoing
15 education and engagement, the red ball. We're consistently
16 doing that. That is something that we, as staff for this
17 project, use any opportunity we get to talk about this, we
18 take it. If you have more opportunities, please contact us.

19 We -- the other two deliverables, and we're going to go
20 into a little bit more depth about these, one is our Healthy
21 Alaskans 2020 actions for success. So that's our health
22 improvement plan for the state, our -- and it's really the
23 implementation plan for how to reach those goals and I'll talk
24 about the different components that's made up of in just a bit
25 and then the other deliverable is our Alaska community

1 capacity review, which is our -- the assessment of our
2 statewide public health system and I'm going to let Emily tell
3 you a little bit about that and I think some of you might have
4 been there. Becky, I know, was there, so thank you very much
5 for participating.

6 MS. READ: Next slide, great, thanks. So I'm going to
7 give you a little bit of background on the community capacity
8 review. This is -- this is the -- the outcome of this review
9 and this event will form the foundation for the -- Alaska's
10 Public Health System Assessment. That's exactly what it's
11 for.

12 It will provide a map and a description of the
13 environment that -- of the public health system in this state.
14 The value of this review will be policy. It will be -- the
15 results can inform all the policy recommendations.

16 Next slide, please. So this event was held on May 15th
17 in Anchorage. It was a big event. The event was designed to
18 produce an assessment of the Alaska public health system based
19 on a very specific tool, you see it here, Version III of a
20 very specific tool, National Public Health Performance
21 Standards.

22 The purpose of the assessment, again, was to identify
23 strengths, challenges, gaps, opportunities that -- within the
24 public health system that will help us and form development of
25 the state health improvement plan.

1 Next slide. This diagram displays -- we call it the
2 jelly bean diagram and it's one of my favorite diagrams, but
3 this diagram displays the -- actually, the broad nature of
4 what we are defining as Alaska's public health system. It is
5 broader than the Division of Public Health. It is broader
6 than ANTHC and the Alaska Tribal Health System. It is
7 inclusive. It includes what we would otherwise consider non-
8 traditional or beyond traditional partners to public health.

9 It includes a broad spectrum of organizations and
10 individuals, but what they all have in common is all of these
11 entities and individuals contribute to the health of Alaskans.
12 So by using this broad definition of the Alaska public health
13 system in evaluating and conducting this assessment, we
14 believe we have strengthened the validity of the output.

15 So that is an important part of this assessment, is to be
16 as inclusive as possible. The event itself involved more than
17 80 content experts from across the state. So we consider that
18 a very successful attendance, yeah (affirmative). It was a
19 pretty amazing thing to be a part of.

20 Next slide, please. So this slide shows the 10 essential
21 public health services that were evaluated in this assessment
22 using this tool. It also displays how we, as Healthy Alaskans
23 2020 planning team, separated out the essential services and
24 formed five work groups. Each of the work groups -- well, I
25 should say that participants were assigned to their work

1 groups based on their areas of specialty, their content
2 expertise and this is basically the 10 public health services
3 that were evaluated throughout the day by five working groups,
4 about 80 people.

5 So the essential public health services were evaluated on
6 four, what are called model standards, and these -- the
7 definition of model standards is slightly different for each
8 essential public health service, but they included planning
9 and implementation, state and local partnerships, program
10 management and quality improvement, and finally, capacity and
11 resources. Again, we had 80-plus people participate.

12 Next slide, and I should add -- I should add that, so
13 this is a preliminary result. So this is -- these are the
14 preliminary results of each of the 10 essential services.
15 This is on a scale of 100, which represents optimal
16 performance in the public health system for these essential
17 services.

18 Alaska strengths, this is preliminary. It is very high
19 level, but Alaska's strengths appear to be in our ability to
20 enforce laws, stands out a little bit, and in our ability to
21 diagnose and investigate health issues. So those are the two
22 stand-outs. Again, this is on a scale of 100, where 100 is
23 the optimal performance.

24 Overall -- overall report back about this particular
25 event is that it was fairly well received. We have a lot of

1 positive feedback from participants. We would have liked to
2 have received a little more rural representation. We had some
3 rural representatives, but not as many as we would have liked.

4 The qualitative -- this right here is the result of
5 voting on the members parts. It is not -- it does not
6 incorporate any type of qualitative analysis. So we did have
7 note-takers and documented a lot of discussion in each of
8 these groups, but this preliminary document does not include
9 any of that. So there will be further analysis with the
10 qualitative information.

11 The report, itself, we expect to have the -- the final
12 report, we expect to have completed at the -- by the end of
13 September and ready and available to be used by people in this
14 field. Today, as a matter of fact, we just sent out or we
15 will be sending out sort of a preliminary results document to
16 the participants who informed our efforts.

17 MS. AQUINO: And back to me, and just to say that
18 information is so critical to us as a part of Healthy Alaskans
19 2020 in creating our actions for success plan because as we
20 put together what our implementation strategy is, we're, you
21 know, I'm going to talk about what we're doing. We're really
22 looking at the evidence base and what content experts agree is
23 the most important things to happen, but it's really important
24 to know what the overall system looks like in that, as well,
25 because even if the experts in the field say, "This is what we

1 really need to do, put our efforts in this area," if there's
2 not support from the system in that area, despite best
3 efforts, we're probably still not going to reach that goal.

4 So we need to look at the information about how the --
5 what the overall system looks like as well and does that make
6 sense? So that's why it's really critical, but it's also much
7 larger than our effort and I hope it's something that all
8 public health planners and community planners can use.

9 So let's talk a little bit about our strategies in
10 action. So this is really the component of our overall health
11 improvement plan that is the action part of our plan in many
12 ways, sort of the meat of the plan, if you will. So we've
13 chosen to really focus on actions that are underway or plan to
14 be underway and we've asked content experts to come to the
15 table in these strategy work groups and I'll talk about that
16 just a little bit more, but we've asked them to come to the
17 table and really, as I say, talk about actions that are
18 currently underway or planned to be underway.

19 We also have collected some sort of wish list, if you
20 will, or actions that content experts think need to happen,
21 but that are not currently underway, but that was really not
22 the focus of what we wanted to do with this. We really wanted
23 to start with things that were happening, so that we could all
24 come together and agree and stand behind those things that we
25 know are going to be happening, because what we found is that

1 often people in the programs, people in these areas, they know
2 what's happening, but that doesn't mean that leadership, or
3 you know, legislators or our Governor or the heads of
4 companies know what's happening.

5 They're not necessarily tied to that and that doesn't
6 mean that communities know what's happening at the state level
7 or the individuals know what's happening in their communities.
8 So we really wanted to take this opportunity to really have
9 one common place where we could all come together and be a
10 part of what's actually happening. Is that -- so that's
11 really been our focus.

12 So our process has been to look at these -- and actually,
13 let's go back, Deb, if you wouldn't mind? These are our
14 strategy work groups and we had 12 strategy work groups that
15 we brought together. Each has a convener. They looked at
16 either one or up to three or four indicators, just depending
17 on the topic. The strategy work groups are made up of content
18 experts from around the state.

19 We tried to get a really broad geographic representation.
20 They were facilitated by conveners and that's who's listed on
21 this table. When we originally planned this, we thought -- we
22 gave every group six weeks because we knew that all of these
23 people were very busy and we didn't want to tax them and we
24 wanted -- and we knew that this was something that potentially
25 could get done like that, but what we learned very quickly is

1 that was too short of a time and I think that really speaks to
2 the degree of the difference between these categories and
3 these indicators, because some of these indicators that were
4 well established statewide networks already, there was --
5 there's already a really strong evidence base about population
6 health in that area, like tobacco.

7 There's a strong evidence base about what works in terms
8 of population health and tobacco. There's a strong statewide
9 network. It was relatively easy for that group to come
10 together and think about strategies and actions. Whereas,
11 around group 12, where we looked at indicators that were more
12 about socioeconomic status, so about poverty -- living below
13 the poverty line and high school graduation, there's multiple
14 efforts.

15 There's a variety of approaches to this that are --
16 they're -- and they're very multifactorial. They really
17 depend on numerous things coming together and there's not just
18 one program that works on, you know, on poverty. There's
19 numerous programs. There's numerous approaches. So not
20 surprisingly, that group has taken a longer time to pull
21 together this information. So let's see, yeah (affirmative),
22 please.

23 COMMISSIONER CAMPBELL: The first thing that strikes me
24 on this slide is that you reduce the cancer mortality rate to
25 162 per 100,000. It would be nice to know what the existing

1 number is that you're shooting for .

2 MS. AQUINO: No, that's a great question. So this is
3 really -- just I put it up as an example, but you're
4 absolutely right, and if you look at -- and even in this
5 handout, this isn't the version that has the baseline, but we
6 do have, and that's available on our website straight up, is
7 we -- all of the -- all of our 25 leading health indicators
8 have a baseline.

9 We have a target for those and we will be tracking those.
10 So we're tracking those regularly and they will be updated at
11 least annually, so -- but absolutely, it's critical that
12 there's a solid baseline and target.

13 MS. ERICKSON: Yeah (affirmative), and I could send the
14 link to some of those reports. There's also another report
15 that has 10-year trend data for each of these indicators, too.
16 So it's helpful to be able to look back and see what change,
17 if any, has occurred over the past decade.

18 MS. AQUINO: And let's -- and we're going to talk about
19 it in a second, but there's also -- all of these are tracked
20 on our IBIS system. So the state of Alaska has the indicator
21 based information system, which is a tremendous resource and
22 the newest data is available on that site all the time.

23 COMMISSIONER HULTBERG: So how do you take these high
24 level goals, which have to be impact -- have to be affected by
25 -- in order to change, have to rely on the actions of lots of

1 organizations and lots of people, so how do you push that down
2 into the people that are going to need to do the work to move
3 (indiscernible)?

4 MS. AQUINO: Great question, and one that we're, you
5 know, struggling with all the time, but one that we've thought
6 about a lot. So when asked the content experts to come
7 together, I'm just going to go back to the form, but I'll
8 speak to this again and again, I hope. We asked them to
9 identify one to three evidence-based strategies, so these are
10 high level -- higher level strategies that they agreed needed
11 to be in place in order for us to be able to reach the decade
12 goal, the health goal for the decade, and then for each of
13 those strategies, we asked them to identify one to five
14 specific action steps that were currently underway or planned
15 to be underway and for each of those -- and those action
16 steps, we asked that they be measurable.

17 So we asked that they identify who the lead partner is
18 who is doing that and what the timeframe is for that and a way
19 to measure that and it -- to get a sense of some of what
20 you're talking about, so it could filter down, but I
21 absolutely acknowledge that this is just -- this is just a
22 layer and that there are multiple layers and we're not getting
23 -- so we're capturing some of the action steps, but there's --
24 for some of the action steps we've found, there's multiple
25 action steps underneath it and we're not going to -- and we're

1 not going to be able to get all of that for right now.

2 What we really wanted this to be, was a starting place,
3 somewhere, where initially all of our partners could come
4 together and see the work that's actually happening and that
5 people that are new to this and coming to the table, they
6 could see who the lead partners are, who are people that are
7 doing work like this in the state that I could look to, that I
8 could go to their website and find out -- if I'm in a
9 community and I know that I want to work in obesity and I look
10 at this and I see that at the state level, a lead partner
11 who's doing some, you know, tremendous work in -- around
12 obesity is whoever, the state (indiscernible) program or
13 whomever, that I know that I can go there and here's specific
14 things as a part of this statewide initiative that all of
15 these partners across the state have agreed to in the sense
16 that they -- like everyone agrees these things are happening.

17 They see the evidence and they see the -- and they
18 support that, not that they necessarily -- everyone agrees
19 that they need to be doing all of this work, but that, rather,
20 that this is important work that is being done right now.
21 Does that help, but I hear -- it's still -- I still -- there's
22 -- it's continual. It's a process and we need to continue to
23 ask those question.

24 MS. READ: I was -- this -- I was just going to reiterate
25 that this is a decades-long process and alignment is really

1 what we're -- we are constantly trying to do, so to constantly
2 try to talk to communities who we reach out to about the goals
3 and discuss them as opportunities for alignment, like on a --
4 someone who's interested in obesity in a small village, this -
5 - we're -- we -- our vision for this is this is going to be
6 helpful to them. So they will know who to contact. They know
7 what -- they will have information on what is evidence-based.
8 So it doesn't force alignment, but it certainly invites it.

9 COMMISSIONER URATA: I think I might have asked this
10 question before, but you know, death from heart attacks and
11 strokes are like number two and number five causes of death in
12 Alaska or among Alaskans and so I was kind of surprised that,
13 at least one of those, were not included, because those have,
14 you know, public health fixes.

15 MS. AQUINO: No, thank you, and I don't know if it was
16 that exact issue. It might have been, but this has come up
17 before and I think we've had a conversation about this before,
18 but it's important and I think we have to keep saying it
19 because, no, it's fine. It's really important. I have to
20 keep saying it to myself because there are -- because we had
21 25 and there are so many important health issues in our state
22 and it was very difficult to get to 25.

23 I mean, Deb can attest. Dr. Hurlburt can attest. It was
24 a challenge, you know, we started with hundreds. We got down
25 to 71. We got to 27. I'm telling you, 27 to 25, it was

1 painful. It was painful, because it's -- this is what, you
2 know, these are our hearts. This is what we do every day.
3 Nobody wanted to get rid of anything, but just let's talk
4 about, in particular, heart disease, absolutely people know
5 that -- people on the advisory team absolutely know that this
6 is a critical issue in Alaska, in the nation, in the world.

7 We looked at mortality rates. We looked at a variety of
8 different pieces of information and I don't know, I can't say
9 exactly, but I can say this, that an important thing that we
10 considered was the root cause of a lot of problems and so in
11 terms of that, I think that's why it was absolutely critical
12 that we have a couple of tobacco-related indicators. We have
13 a couple of obesity and physical activity indicators because I
14 think that was, you know, I think that speaks to that
15 absolutely. I think that's what the advisory team would say,
16 but I hope that I'm representing that well, yeah
17 (affirmative).

18 COMMISSIONER URATA: Well, I think it's a good move.

19 MS. AQUINO: Thank you. Thank you. So anyway, just to
20 say, so we're getting these forms back. We have most of them
21 back. There are still a couple outstanding and now, we're in
22 the stage of asking some clarifying questions, just to make
23 sure that we have the information correctly, that we
24 understand it correctly and then the next stage will be that
25 we, as the staff of this project, are going to do the work or

1 sort of editing this, because there's a lot of information
2 we're collecting.

3 Not all of the information is really vital to every
4 different audience. The public might not want all of this.
5 They might just want some of that. So we're going to be
6 doing, going through some stages of editing, bringing that
7 back to our strategy work groups to make sure that it still
8 reflects their work and then it will start going through an
9 approval process and it will -- we're going to have it go out
10 to the public for their input and approval on it, well, more
11 their input, but it will go to our advisory team and then the
12 final word will be our steering team.

13 So yeah (affirmative), let's go to the next slide. Okay,
14 so this is just a little timeline. It's a strong estimate of
15 our expectation for the coming year and the information you'll
16 see coming out. So Emily talked about our community capacity
17 review. Those preliminary results are going to be coming out
18 really soon, but really those are just primarily going to go
19 back to participants.

20 We are working on the full report where a lot of that
21 qualitative information will be incorporated and that will be
22 -- we're expecting that will be done at the end of September.
23 The strategies and actions that I've just been speaking of,
24 we're hoping to get all the templates back from all the groups
25 by the end of the month, this month, and then we hope to have

1 a draft ready to go to the public for their input at the end
2 of September, as well. That's what we're working toward now.

3 Another piece is a write-up of our statewide health
4 assessment, so that was all of the information that went into
5 -- that informed the prioritization process and that report
6 has been drafted and it's very near to completion. We expect
7 that to be released at the end of July and that should be a
8 really great resource for people. It has a lot of health data
9 around the state and it also speaks to the data we collected
10 from Alaskans about their health priorities, which I think is
11 a really great resource for anyone in health planning.

12 Then finally, the actions for success, which is the
13 complete plan, which incorporates all of these, as well as a
14 write-up of our process, and we're working to complete that by
15 the end of April, and I'm just going to take one second to
16 tell you a little bit why -- about -- it's the end of April,
17 which is not our fiscal year or anyone's, and that is because
18 -- so this project to date has been funded by grants that we
19 got from -- well, actually, they're not grants.

20 It's a cooperative agreement with the CDC called the
21 National Public Health Improvement Initiative and both ANTHC
22 and the State of Alaska Division of Public Health got one and
23 so those grants have funded -- they're not very big, but they
24 fund the staff to do this project.

25 That cooperative agreement, we are at the end -- we're in

1 our fourth year now. We're just going to end our fourth year
2 at the end of September and it -- in the omnibus budget bill
3 that was passed at the federal level, that -- the fifth year
4 of this grant, of that cooperative agreement was zeroed out.
5 So we don't have a fifth year, but that's okay.

6 We are fine with that. We're working on contingencies
7 around that. So we are able to apply for a no-cost extension
8 and we have and so we anticipate that money will get us
9 through the completion of the actions for success and really,
10 what we've created in this is we have the beginnings or the
11 structure and our framework of a backbone to support this work
12 going forward.

13 We have the website. We have IBIS and the data's being
14 tracked. We have some of the really critical pieces for this
15 project to move forward, but we will -- but we are also going
16 to be working with our advisory team to talk about the other
17 aspects of sustainability to make sure that there is a
18 backbone structure for Healthy Alaskans 2020, so that it can
19 move forward and so that this work is supported through the
20 decade. Yeah (affirmative), I don't know if anyone has any
21 questions about that or thoughts. Okay.

22 COMMISSIONER URATA: How much does it cost to sustain it?

23 MS. AQUINO: Well, yeah (affirmative), that's a great
24 question. Really, you know, ideally, especially once we get
25 past these reports being done, it's really just a part of --

1 yeah (affirmative), maintenance, a part of our staff, a part
2 position of both of our agencies, because I think it is really
3 critical, this partnership is really critical. So ideally, it
4 would be a part -- that we could share that, as well as I say,
5 some of the things like the website and the IBIS, but the
6 state, DHSS is really already committed to that and are strong
7 supporters of that of -- and so I am hoping that will -- that
8 commitment will be able to be sustained by the state in terms
9 of the website. Does that make sense? So not much, yeah
10 (affirmative).

11 MS. READ: We'll develop a budget.

12 COMMISSIONER MORGAN: I guess I have to say this; you
13 guys give a presentation each -- as you go through this
14 process at the Municipality of Anchorage Health Community
15 Services Commission, which I'm on and used to Chair, and the
16 Municipality is actually -- uses this document in their public
17 health planning and I bet you our Director or a designee is on
18 your group, at one or the other, I don't know. They bring us
19 up -- they always come in, give a talk and then bring you guys
20 in once you're done and you -- somebody gives a presentation.

21 It would seem to me, I think there's -- it would seem to
22 me, since most of the public health departments on the local
23 level in organized cities, since we -- they utilize this and
24 they really do, they use this to plan, I also think, as a side
25 bar, that simply doing it and talking about these things, I

1 call it the jabber factor, if you're talking about it, people
2 start thinking, "Well, maybe we shouldn't, you know, have soft
3 drinks in the schools," kind of stuff.

4 So it would seem to me that, and I'll bring this up at
5 our meeting next month, my next to the last meeting, too, for
6 that, since I will no longer be a voting person in Anchorage
7 then, that maybe the health departments, since they utilize
8 the document, even if it's just a small amount, should kick in
9 on the budget to help pay for it.

10 I'm sure Juneau Health Department and the Anchorage
11 Health Department, maybe it can be prorated by population or
12 something, but there ought to be some kick-in, because they
13 basically got rid of doing it on the local level and adopted
14 this process as their -- helping their planning document if
15 they're able to reduce man hours in their health department to
16 do it, they ought to kick in a little to help out, I would
17 think.

18 I didn't realize your grant was done. That's the first
19 time I heard that and you keep saying it's just a little bit
20 of money. So it can't be much that they might -- any little
21 bit will help, right, so okay.

22 MS. ERICKSON: Is there much of a linkage with the
23 community hospitals now, the new IRS, relatively new IRS rules
24 that require nonprofit hospitals to conduct community health
25 assessments and develop health improvement plans, are they

1 linking and do you think they would be willing to help pay for
2 supporting this?

3 MS. AQUINO: Yes, yes, and yes. It's actually -- it's a
4 really exciting time. So a couple of things, one is that the
5 conversation that we'll have with our advisory team, all the
6 people or the people you are talking about, they're at the
7 table. They're at the table with us. The new municipality is
8 there or the Anchorage Municipality is there. ASHNA is there.
9 We have folks at the table that can speak about some of these
10 things, but and -- but I -- and as we think about
11 sustainability, but also, I want to talk about or say that
12 there's a new group that's sort of formed coming out of the
13 state, but it's very representative -- it has a lot of
14 representatives from other -- from throughout the state to
15 look at community health improvement and so we're there at the
16 table and it's about supporting communities and completing
17 their community health assessment and doing their community
18 health improvement plan and we're at the table, I'm at the
19 table every day to tell the -- to say and align it with
20 Healthy Alaskans 2020, and we're trying to think about the
21 ways that we can provide support to them to create that
22 alignment, but we already are so -- in so many ways, we hear
23 so often from communities, just having that data available is
24 gigantic and we are striving to make more data available all
25 the time to try to be able to break that down further, if it's

1 possible.

2 So you know, and certainly in terms of funding, that's
3 something that we will -- that we would add into our budget is
4 if there's ways that we can get better data for communities so
5 that they can really be a part of this even more. They can
6 really tie in really more, that would be something that would
7 be really important to us, but absolutely, yeah (affirmative),
8 thinking about partnering with hospitals, as well.

9 MS. READ: So this is, up on the screen here, is a
10 reminder of the Healthy Alaskans 2020 commitment to providing
11 tools and resources to communities and planning -- planners
12 and et cetera across the state, so that, you know, we can
13 provide this information to people who need it.

14 So this is the website, really -- it was mentioned a
15 little earlier, where are the leading health indicators?
16 Where are the targets? Where are the baselines? Where can I
17 find it? It is all here and it will be updated as -- the data
18 will be updated as it can be updated, depending on the source.
19 So this is just a reminder and there it is,
20 healthyalaskans2020@alaska.gov.

21 MS. AQUINO: I think that's all.

22 MS. ERICKSON: That's okay. Does anybody else have any
23 other questions? I'm not hearing any other questions. I have
24 a suggestion and then I probably could wait until an advisory
25 team meeting, but I'll forget by then, and it struck me as you

1 were talking about the community capacity assessment that
2 sometimes public -- we, in public health, can get kind of
3 jargony in our understanding and description about what public
4 health is and my suggestion is to make sure in the beginning
5 of that report that there is a real good lay definition of
6 what public health means, because it can mean lots of
7 different things to lots of different people and I could maybe
8 work with you on that a little bit and I can think of some
9 examples that would make it real meaningful and real to folks.

10 MS. AQUINO: That would be great and yeah (affirmative),
11 thank you very much, and can we go to our last slide, because
12 I just want to take this opportunity, we really liken our
13 framework to blanket toss and that we, as Alaskans, are all
14 around the edge of that blanket and the only way that we can
15 reach that highest height is by using the Healthy Alaskans
16 2020 framework as the blanket and getting up there to reach
17 those goals and I just want to ask all of you that are at the
18 table, first of all, thank you all for your support for this
19 effort and to encourage you, please, if there's any audience
20 that you think would like to hear about this that hasn't heard
21 about it, please contact me or put them in touch with me or
22 with Emily.

23 If there are ideas or ways that you know of for your
24 organizations or who you're representing can be more involved
25 with this, we would really like to have more partners at the

1 table. So thank you for your time.

2 COMMISSIONER URATA: I'm kind of compulsive and what's
3 this bubble for? There's no name under it.

4 MS. ERICKSON: Fill in your name there. That's your
5 bubble.

6 MS. AQUINO: Thank you.

7 MS. ERICKSON: Thank you very much. We're going to fill
8 in Bob's name on that bubble. Well, so I think we're ready to
9 invite Commissioner Streur, do you want to come to the table
10 and join us? We'll take just a two-minute break while we're
11 making the transition, is that okay?

12 2:06:18

13 (Off record)

14 (On record)

15 2:17:13

16 CHAIR HURLBURT: We'll go ahead and get started and Deb,
17 you're continuing to lead this session.

18 MS. ERICKSON: Well, we'll just go ahead and turn it over
19 to the Commissioner. Josh is out of the country and Lori is
20 out of town, but we invited the Commissioner, as usual, to
21 fill us in on the status of federal health care reform
22 activities, related activities and as well as now, the new
23 Medicaid reform advisory group.

24 COMMISSIONER STREUR: Don't put any more words in my
25 mouth, Deb. You know, as Deb did her introduction, I'm

1 thinking, "Why am I here then, if two out of three
2 participants can't be here, I thought I was supposed to make a
3 roll downhill," so anyway.

4 COMMISSIONER MORGAN: Don't you sign their time cards?

5 COMMISSIONER STREUR: I do and I will remember, and I'm
6 going to kind of give you kind of a potpourri of things of,
7 you know, what I see on the horizon with regard to the federal
8 health care law, a little bit of what we're seeing, a little
9 bit of the churn that continues around the federal health care
10 law and I think it's very interesting how the health care law
11 is so front and center with regard to our federal elections in
12 Alaska at this point.

13 I'm one of those skeptics that says that I believe the
14 Affordable Care Act is here to stay. It may be significantly
15 changed, but there are many tenets, I believe, that are going
16 to stick. I think people are finding that there's some value,
17 albeit at significant cost, and that the climate in the
18 Congress is such that they don't have the stomach going
19 forward, at least prior to the next presidential election, to
20 attempt to try to push it through.

21 I know people like Representative Keller are sitting
22 there saying, "Bull," and but, you know, as I read, as I
23 listen to, you know, some pretty conservative congressman, and
24 I read what they're saying now. It's so significantly changed
25 from when the act was hanging there in the edges.

1 The only way we'd beat it, the only way that it can be
2 defeated is to have a, you know, complete turnover in the
3 Congress so that, you know, it's red all the way across, as
4 well as the presidency or such a significant change in the
5 representation that a veto can be held up, but even at that, I
6 think that states, 26 states have gone forward, got -- I
7 received a notice this morning that Terry McAuliffe, the
8 Governor of Virginia, is going to defy his own legislature and
9 push for Medicaid expansion and what he's decided to do is
10 hold up a \$300 million appropriation that the legislature has
11 brought forward to renovate the capital for the state of
12 Virginia. So it's a bit of a standoff there. So it's going
13 to be an interesting one to watch because he hasn't been able
14 to move it to this date.

15 The only other way I think that we'll be able to see any
16 alteration to the Affordable Care Act, significant alteration
17 or significant reduction in the Affordable Care Act is going
18 to be if Congress one day realizes that we do have a dire
19 budget situation in this nation and so far, I don't think that
20 has been, at least recognized by the majority there, and so
21 you know, we're going to continue to watch it.

22 We're going to continue to try to figure out a better way
23 to serve Alaskans and see what we can do to move it forward.
24 Something I wanted to share with you is that earlier this
25 week, an article came out from Keiser, Keiser Foundation,

1 saying that 50% of Obamacare enrollees were previously
2 uninsured.

3 You say, "So," well, DHHS at the federal level about a
4 month ago said 87% were previously uninsured and Keiser
5 noticed some flaws in it and it came out with their study.
6 Rand Corporation came out with a study and said that 30 -- I
7 need this cheater, 36% were previously uninsured and the
8 McKinsey Group came out with a study that said 24% were
9 previously uninsured.

10 So somewhere between 24 and 87% of the enrollees in the
11 Affordable Care Act were previously uninsured and I think
12 that's going to be, you know, part of the churn that we're
13 going to continue to see. Who is really being helped by this?
14 Who are these people, and you know, what's the benefit to cost
15 ratio?

16 So it's -- as -- I only say this because this is the kind
17 of stuff that we have to deal with in the Department as we
18 look at the good, bad, and ugly of Medicaid expansion and
19 Medicaid reform and the advisory group in Medicaid reform and
20 that's what I want to go into right now, because you all know,
21 last November, Governor Parnell came out and said he was going
22 to do two things, that he was going to do a gap study, which
23 we released about a couple of weeks ago now and my days and
24 weeks are running together, so I apologize. It's either an
25 old thing or I'm staying busy, one of the two. So Keith, can

1 you help me out with that and so anyway, but -- so the gap
2 study has been out.

3 It has been released and it's getting a little bit of
4 attention. I'm surprised that there hasn't been a little more
5 vociferous argument about some of the assumptions that we made
6 there. The bottom line is that we've identified that there's
7 10,000 to 12,000 people that may -- who may be in need of
8 medical care, beyond that currently available through the
9 traditional parachute, if you will, the community health
10 centers, IHS services, charity care within a hospital group or
11 a physician's office or other opportunities that are available
12 to them.

13 So what are those 10,000 to 12,000 people look like?
14 That's what we're trying to go into now. I've been working
15 with our Division of Behavioral Health, who seems to have the
16 largest pocket of people who don't have health insurance and
17 receive some form of care and there's about 90 -- well, say
18 10,000. There's about 10,000 people in there and so I'm
19 trying to obtain the financial information on them.

20 What I have gotten so far is that roughly 1,450 have
21 incomes in excess of \$50,000 a year and so now it's drilling
22 down to the other 8,000 or so to find out where they fit, and
23 you know, you say, "Why do you do that?" Well, I do that
24 because these folks are receiving fairly high levels of
25 behavioral health services through the Department and perhaps,

1 we can get an idea, are they a cross-section, are they not a
2 cross-section, you know, what do they represent, because I
3 look at that number and I look at the 10,000 -- 10,000 to
4 12,000 numbers and it's at least going to give me some form of
5 a snapshot.

6 I'd like to be able to get some more clear emergency room
7 data on people that, not necessarily frequent the emergency
8 room, not the high flyers that Margaret may have talked about
9 those a little bit, but folks that come into the emergency
10 room, show occasionally or show up and say, "I haven't been
11 able to get my heart medication," and maybe have a trauma
12 prior to or while they're there and I'm hoping that, you know,
13 our representative from the State Hospital and Nursing Home
14 Association will be able to help us with that. Did you get
15 that, Becky?

16 Okay, but anyway, the other thing that the Governor said
17 was, "We're going to put this committee together to take a
18 look at Medicaid," and that's the Medicaid Reform Advisory
19 Group, brought together nine members. It started out with
20 seven, including the Chair, and it grew to nine.

21 Renae Axelson from Geneva Woods, Senator John Coghill,
22 Dr. Ilona Farr, Senator Heffern, lobbyist, Representative Pete
23 Higgins, Mayor Mike Navarre from Kenai, Gene Peltola, former
24 administrator of YKHC, Yukon-Kuskokwim Health Corporation,
25 John Torgerson, and Kevin Turkington, representing the private

1 sector.

2 To sit down and say, "Okay, you know, what are we going
3 to do? Where's more -- where can more efficiency be
4 gathered?" You know what drives the cost of health care, it's
5 eligibility -- eligibility, utilization and price. You can
6 get different iterations, different variations on that, but
7 it's primarily those three. So we look at eligibility, look
8 at the people that are included in that. We look at
9 utilization of services, benefit package, if you will.

10 We look at the cost of those services, reimbursement rate
11 and let's start out right now and just say that eligibility is
12 going to be tough to address, because we don't have an
13 eligibility in Medicaid that's significantly different than
14 the minimum standards within the state. There's subtle
15 nuances, but basically, it's there.

16 So benefit level or utilization, to me, I group those two
17 together and we have a fairly robust set of optional Medicaid
18 services that are delivered, but let me give you just a little
19 taste of what those Medicaid -- optional Medicaid services
20 are, pharmacy, adult mental health services, excuse me, our
21 waiver services.

22 The waiver services is our fastest growing area and it's
23 in the hundreds of millions of dollars now, and -- but these
24 are folks that are otherwise eligible for nursing home level
25 of care. So we eliminate waiver services, what happens,

1 because we don't have enough nursing home beds, we're going to
2 help the nursing home system in Washington, Oregon, Idaho,
3 Montana flourish by filling them up with Alaskans. So that's
4 -- but we're still going to look at that.

5 We're still going to look at ways we can get efficiencies
6 out of that. Emily has seen some of the stuff that we've
7 looked at and studied, but then you have pharmacy. I know
8 very well that I eliminate pharmacy coverage from my Medicaid
9 recipient, my costs are going to go up. I spend about \$80
10 million a year on pharmacy and I can't tell you the number of
11 people who might otherwise be in a hospital bed if they didn't
12 have their pharmacy, didn't have their prescriptions, didn't
13 have their medication. I've got a couple of physicians who
14 are nodding about that. It's well-known.

15 So as we look through this, it's not easy. One of the
16 areas is with our tribal partners, and you know, how can we
17 better steer tribal members into the Tribal System, because
18 reimbursement for Medicaid on tribal members is that if a
19 tribal member receives health care services in the Tribal
20 System, I get 100% reimbursement from the feds.

21 If that tribal member goes to see Dr. Stinson or Dr.
22 Urata, I get 50 cents of every dollar from the feds and right
23 now, about 40% of the money of the Medicaid dollars that I
24 spend on Medicaid -- on tribal Medicaid recipients is
25 delivered in the Tribal System.

1 There's going to be some number that's going to be
2 because some of the high-level specialty services are simply
3 not going to be available in the Tribal System, but still, to
4 me, 40% with as robust of a Tribal System as we have, seems a
5 bit problematic to me and to me, it's an advantage for the
6 Tribal Systems, as well, because they're getting paid for that
7 service and -- when they deliver it and by the state or by the
8 feds, really, through the state and so we're hoping that we
9 can continue to develop the partnership. The Native Health
10 Board has been very open and willing to work with us on this
11 and as we move forward.

12 So rate, don't cringe, Becky, but we're looking at rates.
13 Alaska probably has the most unique rates -- read the oldest
14 way of paying rates in the nation, because we pay fee-for-
15 service. There are so many different schema that are used in
16 other states to pay for array of services.

17 At the last meeting, I don't know if Jared Kosin came
18 back or not, but Jared Kosin is my Director of Rate Review and
19 Jared brought up some terrible sounding initials, acronyms,
20 DRG, and that's being used in a lot of states. I don't know
21 if Premera used it or not up here.

22 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
23 microphone).

24 COMMISSIONER STREUR: It's -- that is just one of the
25 schema. You can do different bundled rates. You can do

1 bundled rates with certain provider offices for a specialty,
2 so I'm not saying we're going to do any of it. I'm not going
3 to say we're not going to do all of it, but we have to look at
4 that and that's part of the charge to this group is to come up
5 with recommendations and then we present those recommendations
6 to the Governor at the end of October, early November, so that
7 he can then release those with his budget for 2015, along with
8 the recommendation as to what to do about Medicaid expansion
9 or not.

10 The idea out of this is we're going to be able to show
11 and demonstrate that we can save money, should he decide to go
12 ahead, so that it's budget neutral. I went through probably
13 the most challenging budget situation I've gone through this
14 year with the Legislature. I still like these guys, but they
15 certainly did tax the relationship a time or two, but it was
16 very, very challenging and difficult, but you know, I look at
17 the throughput and I look at it every day, throughput through
18 the pipeline.

19 I look at the price per barrel. This morning or today,
20 it closed at around \$112, and so it's, you know, that's good.
21 It's not great, but it's good, but bad on gas prices, because
22 I think you've seen the last time we had gas prices this high,
23 it was 2008, but that's when oil was \$141 a barrel, too. So
24 it's, you know, a significant different setting from there.

25 What the bottom line is, I know there's no new money and

1 until these guys find, you know, that we can produce gas like
2 crazy, ship it to Japan, Russian, wherever they want to send
3 it, you know, we're going to be challenged with that and we
4 have to be very fastidious about what we do and what we spend
5 it on.

6 My waiver programs, that optional service that I talked
7 about earlier, ate up my entire increase this year, received
8 an \$18 million increase, 17 and change increase for the year,
9 at around a \$2.7 billion budget, that's a pretty small number,
10 and we've been able to do that several years in a row, but
11 that whole amount of money went into those waiver programs to
12 sustain them, because they've grown so fast and we're an aging
13 population.

14 Just look around this room, we're an aging population and
15 it's going to get worse before it gets better and that's why
16 it's even more important that we really make this thing work
17 and make the opportunity work.

18 The agendas, and I'll just cover some of the stuff that
19 we went through, some of which I covered here today, we went
20 through the entire range of Medicaid optional services and we
21 talked about what each of those meant and what the downstream
22 effect of eliminating, changing, reducing each of those might
23 be.

24 Each and every meeting, we have public input and it's
25 right after lunch and it's an opportunity for folks to -- Dr.

1 Stinson's thinking, "Folks to nap," but no, it -- to receive
2 input, and you know, we're going to continue to encourage that
3 right up to the end so that -- and the meetings are entirely
4 open and I think it's just a very good opportunity for
5 exchange.

6 We went through the Alaska State Medicaid Plan and the
7 ramifications of that and what that really means and what it
8 is and we went through the Medicaid rates when Jared got in
9 trouble, so -- but those are just some of the things that we
10 did at the last meeting.

11 This meeting coming up next Tuesday, we're going to talk
12 about the gap analysis and we asked the Wilson Agency to give
13 us a parallel gap analysis. So we have an outside private
14 entity without skin in the state game to take a look-see at
15 what's out there.

16 I was, you know, pleasantly surprised because there was a
17 lot of consistency between the two reports, yet they didn't
18 see ours and we didn't see theirs prior to -- we didn't even
19 have discussion on it. We're going to talk about other state
20 reforms, you know, is there a smarter, brighter, better way to
21 do that?

22 One of the challenges that I see that we really have with
23 doing that is that once again, there's no state like Alaska.
24 We're one of two non-managed care states and of the two non-
25 managed care states, at least the other one has a little bit

1 of managed care and we don't have any. So you know, when you
2 look at other state reforms, a lot of them are putting people
3 into specific plans, putting people into specific coverages
4 and those kinds of activities.

5 Then review of Alaska's previous Medicaid reform effort -
6 - when I came to work for the State in 2007, I started a study
7 to figure out if we could squeeze Medicaid a little bit and we
8 actually did a decent job. We had kind of a mini-Medicaid
9 reform group that came together and I think Rep. Keller, were
10 you in that one?

11 REPRESENTATIVE KELLER: Yes.

12 COMMISSIONER STREUR: And it -- we are still reaping
13 benefits from that in a couple of areas. Pharmacy was a big
14 save for us and some of the efforts that we had on that. So
15 we're going to look at those and have a discussion about those
16 and can we leverage other opportunities off of that, and so
17 the ongoing meetings, it scares me, because I estimate I've
18 got four left to get this thing done and what I may do is hold
19 a stakeholder meeting in between and invite the provider
20 community, stakeholders, if you will, to come and have a
21 knock-down drag-out discussion about what we can do.

22 So that's a quick overview of the two things that Deb
23 tasked me with. If you guys have questions, concerns, cheap
24 shots, I'm happy to entertain them. I looked right at Becky
25 when I said that.

1 COMMISSIONER HULTBERG: Why is he looking at me? I was
2 just going to say that I think, you know, the timeframe to get
3 this work done is really limited. I mean, when you consider
4 the complexity of the Medicaid program, it's a heavy lift to
5 make recommendations. So a stakeholder meeting with
6 providers, I think, can -- is a good suggestion if that can
7 help -- help with that timeframe. I hope would not be a
8 knock-down drag-out, I would look at it more as a
9 collaborative effort with a positive outcome, but I guess
10 we'll see, but anyway, I just wanted to acknowledge that's a
11 really compressed timeframe to make change.

12 So I hope even if the group gets to a certain point that,
13 you know, whether it's complete or not, I guess we'll see, but
14 I think it's probably a discussion that will not stop at the
15 end of this -- at the end of the timeframe this group has been
16 established for.

17 COMMISSIONER STREUR: No, I think you're exactly right.
18 I think it's just really opening the door and saying, "Here's
19 where we want to start and begin a process." I think that was
20 the original intent of the previous Medicaid reform group and
21 it's -- I think there's opportunity there, but you know, as I
22 look at -- it's an entitlement and I'm certainly not going to
23 put out anything before the election, but dealing with
24 entitlements, somebody's ox gets gored.

25 You reduce rates. You reduce services. You become more

1 restrictive. Somebody is affected by that and so it has to be
2 an ongoing dialog about how can we do it smarter, you know.
3 Do we put some strong case management on, instead of the top
4 200, on the top 1,000? Do we assign physicians or assign
5 individuals to specific physicians with a management fee to
6 oversee certain populations?

7 A good example, not to point out Dr. Stinson, but I'm
8 going to, with the pain management -- pain medication
9 management program, you know, I think that we paid for that
10 thing multiple times over by the relationship with them and to
11 me, I want to do more of that kind of service, and you know,
12 that it's -- how do we work smarter?

13 How do we act like the private industry, private health
14 care industry does in terms of managing it? Not hurting
15 people, but right care, right time, right place. I got it in,
16 didn't I? Other questions, comments? You guys tired?

17 DR. STINSON: You know we talk about fraud and abuse, I
18 see so many people, Medicaid, but also with other insurance of
19 some sort who have either had hyper care or hypo care, but not
20 the right care. It's the waste and I see people in every week
21 who had surgery for -- probably did not yield anything
22 positive. It sure didn't seem like it, that when they get the
23 right diagnosis, and you know, I've been doing this for 30
24 years now, so I'm -- I'm better now than what I was 25 years
25 ago, I'll put it that way, but -- and sometimes it is amazing

1 to me, fairly simple things coupled with physical therapy, a
2 treatment plan of \$1,000 all together for four weeks, six
3 weeks versus \$100,000 and they're 100,000 times better and I
4 see that, not once in a while, I see that a few times every
5 clinic day and I have no, you know, I think everybody's trying
6 to do the right thing.

7 Everybody's working their skill set. The surgeon sees
8 something that needs surgery. The internist sees something
9 that needs medication. Everybody's working their own skill
10 set and trying to do their best for people and I have
11 absolutely no cure for any of this, except, boy, it's really,
12 really common and there would be a lot of savings there.

13 I have no way to put that in a bottle, except, it sounds
14 like what Jeff was trying to work a little bit getting going
15 here in town with that other group, but more of an
16 observation, than anything else.

17 COMMISSIONER STREUR: It's an observation that, you know,
18 I can put personal testimony to. I refuse to accept the fact
19 that this job might be giving me stomach aches, and you know,
20 talk about active denial, anyway -- and so I went into an
21 internist and he said, "It sounds like your gall bladder to
22 me." I even talked to Ward about it and went to another
23 internist, "Sounds like your gall bladder to me," and I'm
24 going to take it out. I'll gladly take it out and stupid me,
25 I probably should have gone for three and had my gall bladder

1 taken out and it didn't make a bit of difference, and you
2 know, it's -- and I think back now, you know, I've been so
3 fastidious about questioning my health care and I don't know
4 why, I just wanted that stomach ache to go away so bad and so
5 anyway -- but it's just -- I think you're exactly right.

6 The, you know, the hyper, to me, is, you know, a big part
7 of it. Ward and I have had the discussion about the
8 overtreatment that occurs in the United States. Canada has, I
9 believe Ward said, a three-month wait for an average procedure
10 now. Their mortality rate is better than ours. So it says a
11 little something there, too, so.....

12 COMMISSIONER MORGAN: (Indiscernible - too far from
13 microphone) I'm just used to that, so I have attended a couple
14 of your -- of the -- not yours, but our reform group. It
15 seemed -- it -- it -- to me, it sort of reminded me of the
16 Commission in a way that it was -- after the ice was broken,
17 there was a group, a very diverse group, but they all were
18 trying to get there, you know.

19 They were working the concepts and going through this
20 process, sort of, except concentrating on Medicaid and trying
21 to get to where you wanted to go. I just wanted to say one
22 thing, if you really think about the ACA, and I've got the
23 last congressional budget -- time to look at it, there have
24 been almost 38 major changes through executive fiat and
25 probably about 20 minor ones, either not doing something and

1 delaying it or ignoring it or changing it.

2 So in some ways, the whole concept of it has been
3 mutating before our eyes and one of the major ones was the
4 Rand Corporation study you were talking about, where they
5 actually talk about the uninsured, the effect of delaying it,
6 mainly to make the cost of the ACA go up, as you were saying,
7 by every year's delay with the program they set up by the Rand
8 Corporation is about \$12 billion a year of extra cost thrown
9 on top of what the COB and the Rand Corporation said.

10 When this first started, it was supposed to be budget
11 neutral if you did all this stuff and it would be right around
12 \$900 million and then you'd pick up penalties and all these
13 things. The cost now is about 1.3 trillion over 10 years and
14 that's on top of if you get all the penalties because of the
15 subsidies and the things that are happening, but abolishing it
16 or whatever, it's mutating and changing by that invisible hand
17 to fit the circumstances that we're in, but the Rand
18 Corporation study is echoing exactly what you're saying.

19 The costs now are becoming so huge, what parts of this
20 will have to be jettisoned and what parts will have to be
21 changed and what parts will have to be kept and I guess third,
22 I took our Medicaid program -- and dental is another one.
23 Most states do not, except for extreme pain and infection and
24 children, do not cover dental.

25 If you take the Lower 48, most of those programs and

1 especially the Southeast, we have a very wide and deep robust
2 Medicaid program and there's a reason ACA has a rule in there
3 that you've got to bring your Medicaid rates up to Medicare
4 because most states are below it. We're one of the -- maybe
5 one of two states, two or three, that's above it. There's two
6 of us? I knew it was close.

7 So the part that has always worried me is as someone
8 that's operated in an area with a lot of Medicaid, including
9 with a primary care Medicaid contract in Lexington, it's sort
10 of like, you know, I've always felt it was good, you know,
11 when you were dealing with a program that had very little and
12 had very low rates and thirdly I think that 8% and those 15
13 Zip Codes that use 80% of the resources, what you're
14 describing with case management and assigning different --
15 assigning different people or different diagnoses to certain
16 physicians or certain programs, because fundamentally, we have
17 8 to 10%, which we've heard about 116 times, that's using 80%
18 of the cost and resources.

19 Our real problem is not the guy between jobs, his kid
20 breaks his arm and has to go to CHIP for six months or eight
21 months. We have a lot of chronic long-term people that
22 basically have grown up and are still on Medicaid, that 8% or
23 have a chronic disease that's had them falling to the poverty
24 zone, so with -- and I think we even discussed in here, you
25 might not have been here, Commissioner, we were looking at the

1 mandate when this first started.

2 That's why I showed up at the few meetings. I want to
3 try to make the next one, if I'm in town or at least listen
4 in. I still think it's just a humongous task to try to do
5 this, something like this, this quick. I think you're going
6 to try to do it by your scheduling, but I'm assuming that when
7 the Governor gives a deadline, he's sort of not kidding. He's
8 going to want something from you. So it's going to be a very
9 interesting -- we all have our -- as Shakespeare said, "We all
10 have our parts in the play," and I guess we're all going to
11 play it out, but it's very concerning, especially on the cost
12 end and the budget end on the federal level.

13 I agree with everything you said. I don't know if we
14 have that much time here, that budget constraints could start
15 affecting things to change down on us on the federal side
16 before we can adapt and change and evolve into what our
17 colleague, who I really hate losing at the end of the table
18 here, in this whole process.

19 So your guys are working hard, especially on that reform
20 group, but man, it's a toughie, I tell you, because we've been
21 wrestling with it, some of us, for four years and we're still
22 trying to get there, I think, right guys? If that's --
23 whatever that's worth. That's -- I'll throw that in.

24 COMMISSIONER STREUR: I think you make a good point when
25 you say that, in a way, it's not going to be done and what

1 I've told several people is that, you know, the closing
2 statement in our report is going to be, "To be continued,"
3 because I don't see an out.

4 It has to be a continued process and if we walk away with
5 nothing else, it will be a process for continuing Medicaid
6 reform. I think you know in the Department, I know the
7 legislators know this, in the Department, I moved to results-
8 based accountability and we continue to aggressively pursue
9 it. Our budget presentation this coming year, if I'm still
10 around, is going to be entirely a results-based presentation.

11 My hope is that by budget time, if I'm faced with the
12 potential for a reduction in my budget, I'm going to be able
13 to quantitatively and qualitatively demonstrate and explain
14 what that means, and I believe that's going to be a first in
15 the state.

16 We are better than 60% there right now and continuing to
17 move there. It's just been a very, very fulfilling process to
18 see people grab a hold of it and for lights to come on and
19 say, "Now I understand," and begin to identify outcomes, and
20 you know, I spend -- I do a very good job of spending \$2.7
21 billion a year and I didn't know where a lot of that money
22 went.

23 Medicaid, 1.66 billion, how much good are we really doing
24 and that's tough. It's really, really tough. I can give you
25 lots of anecdotal stuff, but sound empirical data hasn't been

1 there, but we're getting there. So I think that's one way to
2 do it is, you know, where's it making a difference? Where
3 isn't it making a difference, and how do we make more robust
4 where it makes a difference and begin to scale back where it
5 doesn't? I think that's what the two men to my right would
6 like to see, so.....

7 REPRESENTATIVE KELLER: If I could just ask a question?
8 Just to make sure, I want to be real clear and understand, the
9 end of October, you're going to give a recommendation to the
10 Governor. In that recommendation will be yes or no, that you
11 should take expansion or you should not take expansion or is
12 the recommendation a broader potential than that?

13 COMMISSIONER STREUR: The recommendation is not related
14 to Medicaid expansion. The recommendation is related to
15 Medicaid reform and how we would like -- how we propose to
16 reform Medicaid to make it much less of a barge and much more
17 of a speed boat.

18 REPRESENTATIVE KELLER: Okay, thanks. Then my question
19 is; when you're looking at eligibility, you use the -- there's
20 a whole spectrum of possibilities there, all the way from,
21 okay, feds, keep every penny you ever tried to give us and
22 we're going to set up our own eligibility standards and this
23 is what they are, and that would be a pretty radical, you
24 know, it would appeal to me, but I don't think it would appeal
25 to many others, but I mean, you've got a whole scale of things

1 there that we can do.

2 If we are to accept the Medicaid expansion, of course,
3 that changes the eligibility standards hugely, too. It makes
4 something that we've never dealt with before and that is, you
5 know, funding for health care for able-bodied employable
6 people, and you know, I guess I'm just echoing what has
7 already been said, I mean, it's an incredibly huge job and I
8 guess we're the audience at some level on the Commission, so
9 we'll be watching.

10 COMMISSIONER STREUR: Sometimes it's better being the --
11 to be in the audience. I'd just as soon be there.

12 REPRESENTATIVE KELLER: Yeah (affirmative).

13 COMMISSIONER MORGAN: I was about to say, actually, it
14 was kind of fun. I've gone to two of the meetings and that --
15 it's -- it was kind of fun watching somebody else on the
16 griddle, I'm telling you, sitting in the back, and boy, the
17 first meeting, even though the Commissioner and everybody
18 there that was up there said, "Our mandate is to reform and
19 review Medicaid to make it," what you said before, you know,
20 the best stuff at the right place and all that stuff, the
21 first six people, which several of us had bet, would it be
22 five people or eight people, the first six people go up and
23 it's about Medicaid expansion and each time, the Commissioner
24 would have to say, "Well, we're not here to do that."

25 It was, like I said, it was kind of fun not being the guy

1 up there and being back there, instead of up here, through
2 that, but he handled -- your guy -- you and that -- the reform
3 work group handled it well. They were, you know, very
4 courteous, very polite, but they kept explaining, we're not
5 here to do that, so.....

6 COMMISSIONER CAMPBELL: In hindsight, did we make -- we,
7 collective, the state, make a mistake in adding all these
8 Medicaid services over the years, over the basic Medicaid
9 requirements from day one?

10 COMMISSIONER STREUR: I don't know that we made a
11 mistake. I don't think it was very thoughtful, though, and
12 what I mean by that is that it may have been a service that
13 benefitted. It may have been a service that was the right
14 thing to do, but we didn't go at it in a complete manner.

15 We didn't think about how we were going to implement it,
16 how we were going to ensure that it was the right population
17 that was receiving those services, that we had checks and
18 balances among the provider community to -- so that the same
19 person assessing the individual is not the person providing
20 the services downstream to that individual.

21 So it wasn't, to me, it wasn't so much the choice of --
22 for the service, but how we implemented it that could have
23 been much improved.

24 REPRESENTATIVE KELLER: Is the -- would you explain, sir,
25 Bill, on is a waiver a broad-based waiver? Is that an option

1 yet at all for us or is that pretty much all by the wayside?
2 I saw that several states did that, right, a real broad, I
3 mean, to cover virtually, you know, put us back in the
4 driver's seat in the management, I mean, is that still an
5 option or not?

6 COMMISSIONER STREUR: If you're talking, you know, the
7 waiver to, you know, to design our own program, just give us
8 some money and we're design our own program and we'll control
9 the rate of increase to, I believe, one of the states for some
10 of their services has a 3% annual increase, something like
11 that, that's still a possibility.

12 I think it's very dangerous and one of the states, it was
13 one of the eastern states, they're in financial trouble right
14 now because they agreed to a 3% -- Arkansas just agreed to a
15 3%, and they're running 8% to 9% and that's all GF, I mean,
16 that's the downside of it.

17 If you don't have a managed program in place and I didn't
18 say "managed," I don't mean managed care. I mean a managed
19 program. You don't have the checks and balances. You don't
20 have the coverage on the super-utilizers that you don't have -
21 - don't have -- don't have -- before you do that, I think it's
22 dangerous.

23 COMMISSIONER HULTBERG: I just wanted to point out, in
24 response to what David said, and I'm not -- I'm just making a
25 statement of fact here, but a lot of states have used Medicaid

1 expansion to drive reform and so while I -- the intent has
2 been very clear of the Medicaid Reform Advisory Group is to
3 look at the existing Medicaid population, I do think that
4 there have been efforts, and I just wanted to point out, in a
5 lot of other states where that expansion has been used as a
6 way to kind of bring everybody to the table to do that.

7 So from that standpoint, yeah (affirmative), it makes
8 sense that people are going to talk about expansion in this
9 group, recognizing that it's certainly, and clearly, and the
10 Commissioner has expressed that it's not the intent of the
11 group. So I just -- I think that's kind of a piece of
12 information I just wanted to make sure was put on the record.

13 COMMISSIONER STREUR: I think that's a given, but the
14 message that was brought to us is you can't reform Medicaid
15 unless you expand it and I strongly disagreed with that and I
16 would rather reform for 140,000 people than 180,000 people and
17 then you give an option for the other 40,000 to come in at
18 that point.

19 So while I don't disagree with what you said, I think
20 that we have to temper it and right now, my charge is not
21 Medicaid, specifically not Medicaid expansion, but reform.

22 COMMISSIONER MORGAN: In defense, the reason I brought up
23 about what kind of program we have, which is a lot wider and
24 deeper and a lot of electives, I think a lot -- some of the
25 expansions were because their program didn't. They were very

1 -- the minimal. Their rates were below Medicare and they
2 didn't have all of those other services.

3 So I mean, Medicaid expansion is a very dynamic issue and
4 you almost have to go state by state to really look at it, but
5 rural states with small populations that have very large, deep
6 and wide Medicaid programs is a little bit different than
7 Mississippi that doesn't have -- has the bare bones, a lot of
8 poor people and doesn't have all the services.

9 It's a different situation. So that's not a statement
10 not to do it. It's just a statement that it's a different
11 circumstance than a lot of the other states and I say that one
12 of our colleagues that used to be on the group is here.

13 COMMISSIONER STREUR: We could iron-fist this thing and
14 we could say that we're going to reduce Medicaid rates to
15 Medicare levels, kind of go with the national trend and I
16 would save 20%. I mean, but I would lose providers. I would
17 lose access, and you know, we'd have more challenges yet with
18 our bush community tribal providers as we deal with a very
19 complicated, but very sophisticated health care system out
20 there.

21 REPRESENTATIVE KELLER: Is there -- are we seeing any
22 increase in the Medicaid, proposed Medicaid budget because of
23 the emphasis that has been put on -- I just read something
24 that some of the states are -- I don't -- it was a new thought
25 to me, but because of the expansion, more people, you know,

1 that originally didn't even pay any attention were now, that
2 were qualified, are now signing up and therefore, the budget
3 increase. Are we seeing that effect up here?

4 COMMISSIONER STREUR: If we are seeing it, it's very,
5 very minimal. You're talking about the woodwork effect people
6 -- people that because of the Affordable Care Act, come out of
7 the woodwork and they apply for insurance and they find out
8 they're qualified for Medicaid. We're seeing very small
9 number on that in Alaska.

10 In fact, the overall enrollment in Alaska has been very
11 small numbers in, what's it called, Enroll Alaska? I believe
12 that they are scaling considerably back as result of just not
13 getting the population numbers that were expected, not their
14 fault. It's just that, you know, people haven't embraced it.

15 CHAIR HURLBURT: Thank you. We'll see if there are
16 anymore questions, but I'd like to welcome Senator Olson, who
17 was here at the beginning with us, as a member of the
18 Commission, and sponsored the legislation that several of us
19 where there for the signing with the Governor the other day
20 and we appreciate that support and your continued interest.
21 So whenever you come, you are welcome at the table, Senator
22 Olson, so.....

23 SENATOR OLSON: Thank you for that opportunity. It's
24 good to see everybody back (indiscernible - too far from
25 microphone).

1 COMMISSIONER CAMPBELL: Just one minor criticism in
2 renewal, he didn't double our salaries.

3 CHAIR HURLBURT: Yes, he did.

4 COMMISSIONER STREUR: Thank you, all.

5 CHAIR HURLBURT: Thank you very much, Commissioner,
6 for.....

7 MS. ERICKSON: Commissioner, we actually had you on our
8 agenda for longer this afternoon, but we may have already
9 taken too much of your time.

10 COMMISSIONER STREUR: Well, I've let you off the hook,
11 then. You know, I'm happy to stay if you have other issues
12 you want to discuss, but otherwise, I'm not here to frat
13 around.

14 MS. ERICKSON: Well, our thought for the rest of the day
15 was that we would reflect back to each other a little bit what
16 we felt like we learned and our take-aways from this meeting
17 and share those with you and maybe get a little bit of your
18 feedback on that. That's how we thought we would structure
19 the rest of the day. We don't have -- don't need to take a
20 whole lot more time, but.....

21 COMMISSIONER STREUR: It's Friday afternoon. It's sunny.
22 Why would you do this to them?

23 MS. ERICKSON: They're the ones who directed me to meet
24 for -- that they wanted to meet for two full days, instead of
25 a half day on the second day.

1 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
2 microphone) didn't think of that.

3 MS. ERICKSON: We'll talk about that at the -- in our
4 meeting reflections at the end of the day. Yes, Senator
5 Olson.

6 SENATOR OLSON: I do have a question to the Commissioner
7 and that is there is obviously.....

8 UNIDENTIFIED SPEAKER: Push the button.

9 MS. ERICKSON: Push your button.

10 SENATOR OLSON:has been a number of -- the lower --
11 the numbers are lower than you anticipated. Do you anticipate
12 that to be the same in the next year or two, as well?

13 COMMISSIONER STREUR: I really can't answer that, because
14 I really thought we would see more people come out of the
15 woodwork than we have. Actually, I was -- we were projecting
16 in the neighborhood of 8,000 the first year and we're just not
17 seeing -- our enrollment, our churn -- churn plus new
18 enrollment, the churn is people that go in and come out on a
19 regular basis, is -- the numbers are almost the same as what
20 they were prior to the Affordable Care Act. So we're not
21 seeing, you know, any if -- very incremental growth.

22 SENATOR OLSON: And a follow onto that question has to do
23 with the budget for Medicaid for the next year, since you are
24 on the Finance Committee, and I'm assuming you're going to be
25 back on there again, what is that -- what does your forecast

1 do or what does -- how is it going to be reflected in the
2 Medicaid request this coming fiscal year?

3 COMMISSIONER STREUR: Well, I think that you know of the
4 last three years, we've been one, one-and-a-half and 3% going
5 back. So it's 3%, one-and-a-half, and now, one percent this
6 last year, less than one percent and I'm hopeful that we can
7 maintain that, but having run an insurance plan, and I think
8 Jeff can back me up on this, it seems to go in four-year
9 cycles, and you know, that's my fourth year, and you know, I
10 expect to probably see some growth again.

11 SENATOR OLSON: Thank you.

12 REPRESENTATIVE KELLER: Can I ask one more?

13 CHAIR HURLBURT: Please, Wes.

14 REPRESENTATIVE KELLER: I -- and I apologize, but I'm
15 glad we've got the time, the -- I have not looked at the
16 report very carefully, but I was wondering -- I think I, from
17 what you said, I think I can surmise that the people that have
18 access to the emergency room as a, you know, it's kind of --
19 it's perverted, but as a healthcare source were -- are
20 included in the gap numbers that you found and I was also
21 wondering a little bit more definition on like those that have
22 access to a community health center, I mean, how was that --
23 can you give me some kind of an idea how -- who would, you
24 said, is in the gap and who isn't in the gap? Was there a
25 circle drawn around some of the facilities? Did it have to do

1 with geography, and maybe, you know, that's a real broad
2 question. Go ahead, you can answer it any way you want.

3 COMMISSIONER STREUR: Your question is exactly the
4 challenge that we have with the gap analysis, because if I
5 look at community health centers and the report that they give
6 me on an annual basis, they serve 90,000 unduplicated,
7 uninsured folks a year, okay. Yet, we say we have 44,000
8 uninsured folks in the gap, if you will, a year.

9 So I take those numbers. I look at the 10,000 that I
10 serve in behavioral health services under grants, and you
11 know, it's putting together all those numbers. They add up to
12 far more than the 44,000 that, you know, we started out that
13 were out there and those 44,000 allegedly included IHS
14 recipients, who were otherwise uninsured.

15 So it's -- that's where I've had the greatest struggle.
16 I can't take the numbers of other providers and make them
17 equate to this 44,000 number that both the ANTHC study and the
18 state study came up with. So it's -- as we begin to chisel it
19 down, we took the tribal members who have access, we believe,
20 to IHS services off the list, whether it's adequate or
21 inadequate, we didn't go into that, but that they do have --
22 they're tribal members. They have access to tribal services.

23 We took those off. We took others off who are otherwise
24 eligible for the services, such as the CAMA Program, such as
25 special pharmacy programs that are available and just began to

1 chisel that down and I think the 10,000 to 12,000 number is a
2 good number, but what do those folks look like?

3 You know, what is the extent of their health care needs?
4 You know, are 9,000 of those with chronic conditions that
5 prevent them from being able to work, being able to rise above
6 the 100% poverty level -- childless adults, we do know that
7 for the most part, that they're childless adults making 100%
8 or less of the federal poverty level and -- but we don't know
9 a lot beyond that.

10 REPRESENTATIVE KELLER: Okay, thank you.

11 CHAIR HURLBURT: Anything else? Okay, again, thank you
12 very much.

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

15 MS. ERICKSON: If you would, I need (indiscernible - too
16 far from microphone) turn off your mics. There we go. So on
17 our agenda for the rest of the afternoon, we actually had a
18 continuing conversation with Commissioner Streur just sharing
19 the group's kind of major take-aways from our meeting the past
20 day-and-a-half and letting you respond to those, Commissioner,
21 and to the extent that you're comfortable doing so.

22 So if you do have time to stay with us for at least maybe
23 another 15 or 20 minutes, if we can get through it that
24 quickly?

25 COMMISSIONER STREUR: I'll stay.

1 MS. ERICKSON: Thank you very much. So what Barb just
2 handed out to you all -- this morning you received the notes
3 from yesterday's discussion and Barb just gave you the raw
4 notes from all of the notes that I've taken today, starting
5 with the reflections you all shared this morning and your main
6 take-aways from yesterday and I just wanted to help -- we're
7 not going to go over that, but I just wanted you to have it at
8 your fingertips so you could be reminded and think about any
9 main points you were making throughout the day and questions
10 that you had and maybe I'll just kind of organize it.

11 Commissioner and Senator Olson, we've spent this meeting
12 focused on kind of three main topics. One was learning more
13 about what employers are doing in Alaska right now related to
14 -- goodbye, Dr. Stinson -- related to employee benefits and
15 employer-sponsored insurance and the Department of Labor and
16 ICER just completed a study and presented the highlights from
17 the data of their analysis on what employers are doing these
18 days related to employer-sponsored insurance or employee
19 health benefits and wellness programs. So we spent some time
20 learning about that and discussing employer issues when it
21 comes to health and healthcare.

22 We spent time discussing transparency and the need for
23 more transparency in health care price and quality in the
24 state, but the best way to go about it, given the complexities
25 related to that and then this morning, we spent the morning

1 focused on fraud and abuse prevention and control, and so
2 maybe I'll start with that and we can work our way backwards,
3 because the Commission, the one area where we addressed
4 directly potential recommendations for the state from the
5 Commission were related to fraud and abuse and specifically to
6 Medicaid, since that's the one area where, I think, the state
7 will have the most opportunity for actually enacting some sort
8 of policy change and maybe I'll just start and folks can share
9 their major thoughts and if we could share with you some of
10 the preliminary, just general thoughts about what
11 recommendations might be -- maybe you can either ask some
12 clarifying questions or answer some questions of the group and
13 maybe even respond whether you think it would be a good idea
14 or not, but I think my first, and I might be projecting a
15 little bit too much what the -- I thought this group was
16 thinking, but my sense was folks were really impressed with
17 the level of collaboration between your Department and the
18 Department of Law and the work that they're doing together,
19 across both, the Medicaid Integrity Program and the Medicaid
20 Control Fraud -- Medicaid Fraud Control Unit and Department of
21 Law and also Health Care Services and how they're all linking
22 together that way.

23 That was really impressive and seemed to be a real
24 positive relatively new development and they brought some
25 ideas forward. Those staff leaders from those units brought

1 some ideas forward to the group that we might see evolve, but
2 does -- I'll just open it up to the group to share their
3 thoughts with you and what they thought their major take-aways
4 from that discussion and ideas and see what you might think.

5 COMMISSIONER CAMPBELL: In relation to fraud and abuse,
6 do you see any major stumbling blocks, either from statute or
7 regulations that you have to overcome to really put lots of
8 bite in this fight?

9 COMMISSIONER STREUR: Yes, that's the short answer. Once
10 we identify someone who's committed fraud, it's pretty
11 difficult to affect any kind of recovery. I blame the
12 Department of Law. I do it a bit tongue and cheek, and I say
13 they're too timid to prosecute, but even when we identify
14 somebody, seizing property, seizing equipment, when they
15 extorted millions of dollars from the Department and we aren't
16 able to grab property, grab anything like that, and we ought
17 to be able to do that because the only way I get their
18 attention is to make it hurt.

19 We recently had a case, you know, it's no secret, Good
20 Faith, and they -- I think we prosecuted them for 49 or 50 of
21 their PCAs or personal care attendants that worked for them,
22 but to my way of thinking, the company walked away scott free,
23 yet we paid the company and they, in turn, paid the people.
24 So you know, who's responsible, and you know, I don't know
25 whether that's a statute thing or a change in philosophy or a

1 change in the way that we prosecute cases, but I think there's
2 some opportunity there and Andrew, Andrew Peterson, who was
3 here, by the way, Deb says, "Recent change," I have seen no
4 where else, in the state of Alaska, a program able to turn
5 completely around as I've seen our prosecution and work with
6 the Department of Law.

7 Andrew came in, I like to talk about the young guns being
8 the ones who don't care or don't know what they don't know or
9 what they can't do, and I mean, that was really the case and I
10 issued a challenge to him, personally issued a challenge to
11 him that I want to fix this thing and told my folks, "Whatever
12 you need, whatever the -- we can do, we need to work with
13 them," and it wasn't me doing it, it was those two groups
14 getting together and making that change and so what we're
15 going to do next is work on statute recommendations that we
16 need to bend, staple, and mutilate to be able to make this
17 program work effectively.

18 I don't know that there's 10% fraud in this state. I
19 don't believe that there's 10% fraud in this state, but
20 there's substantial fraud in this state. Since November,
21 we've prosecuted 99 people. What does that say? That's a
22 pretty fertile field.

23 COMMISSIONER MORGAN: Since Dr. Stinson left, there was a
24 question on opiates and to all of our surprise, and I think,
25 astonishment, your Medicaid fraud and abuse or your

1 Medicaid.....

2 UNIDENTIFIED SPEAKER: Review.

3 COMMISSIONER MORGAN:review.

4 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
5 microphone) tried to control (indiscernible - too far from
6 microphone).....

7 COMMISSIONER MORGAN: Can't look at the -- into the
8 database to see if somebody is taking a prescription to
9 Walgreens and then three hours later, going to somewhere else
10 and buying it with cash, you know, basically, and looking for
11 those patterns, and I mean, I was -- everybody, kind of their
12 jaw dropped, I think, and we were a little bit surprised and I
13 know the federal money's run out, but I've -- I'm pretty sure
14 that this is one -- another -- in the same way that the first
15 reform group that Wes was on, attacked pharmacy and developed
16 a better way of doing and saved a lot of money, I think we've
17 got a lot of issues there, since it's basically more people
18 die from that than from any other thing going on.

19 I was hoping that, at least through statute -- that's
20 what they said, they can change that so you guys can, through
21 a proper process with good protections, but somebody in
22 Medicaid ought to be able to look at that to find these guys,
23 it seems to me.

24 COMMISSIONER STREUR: We're working on that, but yes, we
25 work it out. It was a decision that was made when the

1 original bill was passed, Senator Lyda Green's bill, to
2 implement the prescription database. It took three years to
3 get it up and running, even though the feds provided the
4 software. They provided the support and everything else.
5 Some things move slow in government and I know that's a
6 surprise, but once we got it up and running, it immediately
7 began to give rewards.

8 In the terms of -- or excuse me, in the case of hospital
9 emergency rooms being able to -- physicians being able to go
10 into that database and take a look at Joe Jones and see the
11 fact that, well, he was in Providence a month ago. He was in
12 Regional two weeks ago and now he's here in the Mat-Su, and he
13 has back problems and -- but he's getting massive doses of
14 oxycodone from us, but he was coherent when he presented. He
15 was all this so what's he doing with that oxycodone, and so I
16 was up in Mat-Su, at the hospital up there, and was walking
17 around with the administrator and he introduced me to the
18 emergency room physicians and they just leaped on me about,
19 don't get rid of that program, and so I funded it out of the
20 Department resources last year and am working now with Susan
21 Bell on continued funding, upgrading the software system
22 between us to continue to have more current up-to-date data on
23 that.

24 I think it's a critical program. I think it's probably
25 one of the smarter things that we can do for a relatively

1 small expense, but people wiser than me decided that it wasn't
2 a priority to change . I believe that we can get that data if
3 we need to get that data. It's just going to take more
4 difficulty . Like with the Troopers, we would probably have
5 to get a warrant to be able -- but the nice thing about us
6 being able to control the database and look at Medicaid
7 recipients, we can see if they're buying more in addition to
8 what they're getting through the Department and see if we have
9 a pattern there.

10 Dr. Stinson has left. He's been very helpful to us on
11 our pain medication program by doing the secondary reviews for
12 us and it's been a significant drop in the number of
13 prescriptions that are followed through on because he places a
14 call to a prescribing physician and in most cases, the
15 prescription's withdrawn.

16 COMMISSIONER MORGAN: I'm kind of being his surrogate.
17 He asked me to kind of talk about this. What he was also
18 saying is for you to be able to control the Medicaid info that
19 you do have, there's -- he's now -- he believes that there's
20 groups that will take the prescription and get it under
21 Medicaid and then buy it with cash.

22 So I'm assuming, if it's cash, that it's not in your
23 Medicaid info. So how would -- so you -- you'd almost have to
24 have access in a way.

25 COMMISSION STREUR: That's what I meant by being able to

1 control it and -- which would be good, but we have to be
2 suspicious on somebody and get a warrant right now, under the
3 current situation, in cooperation with public safety or
4 somebody like that to be able to go in and take a look at that
5 person's -- where they're getting their prescriptions from and
6 that . So it is -- it's eligible. It's just more work and
7 we're going to make another run at it next year and we're
8 going to, hopefully, educate more folks than we did this year.

9 We got a little led astray when DCCED, the Board of
10 Pharmacy came out with their estimate of what the upgraded
11 software would cost. They came out with an \$800,000 number
12 and I screamed and kicked my feet and did those things and
13 with a do-over, I think it was 80,000, is what they came back
14 with, but by then, it was too late. I mean, everything was
15 all backed up and so we just quit pushing.

16 UNIDENTIFIED SPEAKER: Which I watched with my mouth
17 hanging open.

18 MS. ERICKSON: Any other questions or comments for the
19 Commissioner related to fraud control? How about anything
20 related to what we learned from the employer survey, not
21 directly related to Medicaid? Yes, Allen.

22 COMMISSIONER HIPPLER: I'm not quite sure if this was in
23 the employer survey, but Jeff, our -- you're not our erstwhile
24 member yet, but soon you will be. He was talking about the
25 current regulation in state regulated insurance plans

1 regarding 80% of UCR or the 80th percentile of UCR, excuse me,
2 as sort of setting the market price. Is Medicaid affected by
3 that at all?

4 COMMISSIONER STREUR: The short answer is no.

5 COMMISSIONER DAVIS: May I offer an alternative?

6 COMMISSIONER MORGAN: Are you disagreeing with me?

7 UNIDENTIFIED SPEAKER: Never disagree with the
8 Commissioner.

9 COMMISSIONER DAVIS: To me, it's a nuance. Directly no,
10 but indirectly, I believe it does, because it sets a market
11 rate that then you're compared to. So I do believe it drives
12 inflation for you, as well.

13 COMMISSIONER HIPPLER: So to follow up, let's say that a
14 medical care provider who can -- who has a very substantial
15 market share of a very specific and specialized code, medical
16 code, let's say that this medical care provider increases
17 their rates for this code by 100% in this year, so that the
18 next year, the 80th percentile would -- this medical care
19 provider controls enough of the market that the 80th
20 percentile would increase by 100%.

21 Would that -- and in theory, the market prices would
22 change as well. Does Medicaid take numbers from -- in that
23 situation, would Medicaid reimbursement increase by 100%?

24 COMMISSIONER STREUR: It does not. Medicaid rates are
25 based on a formula that is kind of a take-off of the Medicare

1 rates. It's a Medicare rate plus a percentage. What -- and
2 so far, we've been able to do that. Where, I think, Jeff was
3 going on it is that, you know, if the rate goes up to \$2,000
4 and Medicaid's paying 140, eventually, Medicaid's going to be
5 pressured to move to that level and -- and basically stray
6 away from, you know, if I want cardiology services in
7 Anchorage, I don't have a lot of choices. Alaska Heart, you
8 know, is my choice, and you know, while I have an open access
9 to them, if the insurance carriers go along with this and
10 stick with the -- I don't like the 80th percentile.

11 If I were back in the private sector, I'd be right where
12 Jeff is, so -- but Medicaid right now is not affected in the
13 short-run. However, if we lose access, Medicaid is affected.

14 MS. ERICKSON: Another question that came up when we were
15 learning about what employers are doing relative to employee
16 wellness and -- was what other -- what public insurers are
17 doing related to wellness and if they're -- if -- is Medicaid
18 using any wellness incentives right now and is that something
19 that you expect the Medicaid Reform Advisory Group to address?

20 COMMISSIONER STREUR: To me, that is the answer. The
21 more I can put back in the hands of primary care providers,
22 the management and oversight and steerage of health care, the
23 better off I'm going to be and then you say, "Well, primary
24 care providers, that's not necessarily wellness," it's very,
25 very close to it and I go into a primary care physician's

1 office, I see more wellness than when I go into my internal
2 medicine office, because I'm there for sickness when I go to
3 internal medicine. Even my physical is different. Quit
4 smiling, Deb, I'm not going to graphically explain the
5 difference.

6 COMMISSIONER MORGAN: She was reaching for a rubber
7 glove.

8 MS. ERICKSON: Okay, we are getting kind of punchy. So
9 we probably should wrap up with transparency. So as we talked
10 at length and kept coming back and revisiting transparency
11 yesterday, we have a number of recommendations on the books
12 currently related to transparency and you actually implemented
13 one of those recommendations related to the Hospital Discharge
14 Database.

15 So I don't -- folks may or may not have any questions
16 about that. We just basically updated them on the status of
17 that yesterday and let them know that your staff already
18 started working on the provider education piece just this week
19 on that program, but we also -- didn't spend too much time
20 talking directly about the All-Payer Claims Database. We're
21 working on a paper with key elements that should be considered
22 in state legislation, if and when, that goes forward, but we
23 also considered what other states do related to transparency
24 laws, mostly requiring submission of data, either to the state
25 or directly to the public or to the state to provide to the

1 public from both healthcare providers and insurers.

2 There are lots of questions and concerns about that, so -
3 - and a real tension. I mean, we've had this tension for the
4 three years we've been talking about transparency and we just
5 continued that conversation and we need to keep revisiting
6 those questions.

7 So folks might want to reflect back on that with you for
8 a few minutes and then, if we can wrap up the meeting, if we
9 can decide on the fly, the Chair and I, you can just bop me if
10 you want to do something different, the one thing we didn't
11 talk about yesterday is whether we should have a stakeholder
12 session on transparency this fall, and if so, what are some
13 things to consider? What direction do you want to give to me
14 to move that forward and maybe we can get the Commissioner's
15 thoughts on that, too.

16 So I'll just open it up to the group to share any
17 thoughts from yesterday and this morning about transparency
18 generally and then we can wrap up with the stakeholder
19 question. Does that sound like a good idea or do you want to
20 do something different?

21 CHAIR HURLBURT: No, I think that sounds fine and -- but
22 I think we're -- on the All-Payer Claims Database, I think
23 almost all of us are convinced that conceptually that's a good
24 thing to do with a lot of potential, but maybe with the
25 exception of New Hampshire, it has not been a resounding

1 success and I, for example, cited the experience of Texas,
2 where they've had the data since 2007, and about two out of
3 100 people use it, so not widely used, but the new thing that
4 I've become aware of recently, and both Deb and I have
5 mentioned it here, is the collaboration between Aetna, Humana
6 and United where, from the insurance payer side, they are
7 coming together in the private sector without government doing
8 it, but providing that information, and I have not seen it
9 stated as to whether their non-enrollees will have access, but
10 where, I think, probably in your sense of priorities, the
11 Hospital Discharge Database has been something we've been
12 making better progress on and you felt we'd get a quicker
13 payoff on that, but that's a different process than the All-
14 Payer Claims Database.

15 I would ask, if related to an All-Payer Claims Database,
16 if you've had any input from others that you've talked with or
17 yourself as far as whether the new venture by the insurance
18 companies might be something that would be more practical,
19 particularly in the budget situation where it would take state
20 -- additional state money to have an All-Payer Claims Database
21 here? Does that make sense?

22 COMMISSIONER STREUR: It does. Both Ward and well, just
23 about everybody in here -- I have a healthy skepticism toward
24 transparency because, as I said to Deb the other day, "You
25 know, what you see is where you're standing." With the

1 different restructures that we have, with the different plans
2 that we have, with the different payment schemes that we have,
3 it's really tough, and that -- I did talk to New Hampshire
4 about it, and they said the struggle that they have is getting
5 people engaged because they get confused, and you know, they -
6 - the word that Nick used was we dumbed it down, so that we
7 didn't have the level of detail, that we're still collecting
8 the level of detail, but the front facing was simpler and
9 easier to read and they think that's why they've had the
10 success there, but until we get the consumer to be a part of
11 the stool, the three-legged stool, I don't think there's going
12 to be, you know, a hue and cry to understand that.

13 I haven't really looked at the UHC stuff. I think the
14 UHC was the one who had initiated it. I think Aetna and --
15 were brought along, but -- so I can't speak to that, but we
16 just -- to me, the more important thing -- the most important
17 thing is to get the consumer engaged in their health care,
18 whether it be cost, whether it be the utilization, whether it
19 be healthier lifestyle, you know, whatever it is, that, to me,
20 has got to be a part of it and there it goes to your wellness
21 focus, but the reason that I pushed the Hospital Discharge
22 Data is that, 1) I can do it under regulation, and 2) I was
23 losing key hospitals in submitting the data because they said,
24 "Our data is being used as a marketing scheme for other
25 hospitals," and other hospitals I went to and said, "You know,

1 I'd like you to come onboard." They said, "We ain't coming
2 onboard because, you know, we're engaged in open competition
3 on this and until there's a level playing field, we're not
4 going to play," and I think that what we put together with the
5 Discharge Database by bringing in like and similar providers,
6 so that you've got a surgery center, you've got nursing homes,
7 you've got hospitals all involved in the data.

8 There's a pretty good sizeable group -- groups involved
9 in this. I think we're going to, at least, get some data and
10 to make another run at the All-Payer Claims Database, we have
11 to figure out, you know, be very clear about what it is we're
12 hoping to get out of that, so.....

13 CHAIR HURLBURT: How about the thoughts about the
14 stakeholder group related to transparency and kind of evolving
15 our role to be more of a convener, maybe any comments from the
16 members of the Commission or Commissioner Streur? Yeah
17 (affirmative), Keith.

18 COMMISSIONER CAMPBELL: I guess I, if I were a provider,
19 I'd -- unless I was assured everybody was going to be at this
20 meeting and bought into it, I'd be pretty darn skeptical that
21 I'd be out there participating alone or in a very small group
22 and I think you can convene the meeting, but I don't know how
23 you make the carrot big enough that you're going to get
24 everybody around the pool.

25 COMMISSIONER URATA: I think that it's going to be very

1 difficult to have a really good All-Payer Claims Database and
2 I don't know if this is a good comparison, but I remember tort
3 reform, before we got tort reform and it was very difficult to
4 do and then finally -- and then no one knew whether it was
5 going to do any good.

6 Finally, and you folks might correct me if I'm wrong, but
7 from my perspective, it seemed like California figured out how
8 to do it and so we sort of copied California and lo and
9 behold, it's working and so I'm thinking, "Gee, because it's
10 so difficult to do, why don't we kind of keep track of how
11 other states are doing and try to figure out if any of them
12 are successful, then jump onboard, but you know, that means --
13 that takes time," and so anyway, in terms of the meeting, I
14 would be interested in seeing how that -- I would be
15 interested in seeing or doing that and seeing what people have
16 to say. So I would agree with a stakeholder meeting.

17 CHAIR HURLBURT: One on each side, and the other.....

18 COMMISSIONER URATA: But there are nine of us, right?

19 CHAIR HURLBURT: Yeah (affirmative), we don't need to
20 take another -- take a formal vote, but yeah (affirmative),
21 and any other.....

22 UNIDENTIFIED SPEAKER: We're going counterclockwise
23 (indiscernible - too far microphone).

24 CHAIR HURLBURT:comments? Jeff, yeah
25 (affirmative).

1 COMMISSIONER DAVIS: So I'm secretly, except I told
2 Becky, being glad that if we do have a stakeholder session, I
3 won't be there, and I may be wrong about this, since we're
4 wrong about lots of things, but this is so complicated and
5 there's so much misinformation, and you can't even say what it
6 is, because it could be a universe of things, that it almost
7 seems to me better to concentrate on having people who've done
8 it well, and I spoke about that I know the commercial carriers
9 and Blue Crosses are doing -- that create consumer tools that
10 are useable, not dumbed down too much. They're not perfect,
11 but they're better than nothing, learn more about what they're
12 doing and have, maybe, form a bit of a strawman about what it
13 is we're really talking about and then, at that point in time,
14 you have something for people to react to, rather than just a
15 free for all of ideas and opinions.

16 So I think I would go more in that direction, not at the
17 expense of involving the stakeholders, but that it's not time
18 yet, and I don't see it being really productive at this point
19 in time. Thank you.

20 CHAIR HURLBURT: In the interest of efficiency, we could
21 probably have a show of hands, but before we do, is there
22 anybody else, Becky.....

23 COMMISSIONER HULTBERG: So I'll talk after Jeff. It's
24 always safe to talk after Jeff.

25 UNIDENTIFIED SPEAKER: I don't even know what that means

1 (indiscernible - too far from microphone).

2 COMMISSIONER HULTBERG: I just would echo his comments.
3 I think there are a lot of providers probably wrestling with
4 this very issue right now, as you heard, you know, Dr. Stinson
5 mention, you know, an incident, you know, his experience with
6 that, with transparency recently, and so I think that it may
7 not -- the time may not be right, because we are all wrestling
8 with this, but have not fully formed what we necessarily think
9 or would recommend, that if we maybe give that a little more
10 time, continue to have it on the agenda, because -- to talk
11 about, find other, you know, other -- maybe, you know, I don't
12 know exactly who's come to the Commission to talk about
13 transparency, but I suspect there are others -- other --
14 others we could invite in to share experiences and then, I
15 think, we'll probably -- maybe we'll know when the time is
16 right to convene that stakeholder session. It just does feel
17 a little premature this fall, for me.

18 CHAIR HURLBURT: But one thing we haven't mentioned here
19 is that, just a day or two before our meeting, we did receive
20 notice from Val that she was resigning. Val has resigned --
21 has retired from ANTHC and probably will be moving onto
22 another chapter, but one of the very valuable functions that
23 Val provided for us here was being an attorney, that I could
24 ask these questions to, and so I think I will ask Allen,
25 because under the rules of order, can we have an informal show

1 of hands or do we need a formal motion to react to.....

2 COMMISSIONER HIPPLER: Under the rules of order, you need
3 a motion, but you're the Chairman. You can always ask for
4 unanimous consent. You can ask for unanimous consent and then
5 say, "Does anybody object?" That's not quite there but this
6 is your game.

7 CHAIR HURLBURT: Okay. Thank you. I often say that
8 physicians can get away with a lot of things that normal
9 people can't, but yes, Wes.

10 REPRESENTATIVE KELLER: Because we're talking about
11 potential legislation to get this done for two cents here I'll
12 let the legislators help me out, I don't hear, you know, this
13 -- I don't see this as an issue that has come up in the
14 Legislature, you know, and so I don't, you know, I don't think
15 that it makes much difference if we do or don't but if there
16 is momentum politically, if it comes up, then we will have put
17 ourselves in a real bad position because if you're not, how do
18 they say that, "If you're not at the table, you may be on the
19 menu," you know, so it may be good -- it may be good to lead
20 with some good advice here.

21 CHAIR HURLBURT: Jim and then David.

22 MR. PUCKETT: And your -- I just want to make sure I'm
23 following this correctly. You're asking about an employer
24 stakeholder meeting or just stakeholders in general?

25 CHAIR HURLBURT: In my mind, it would be stakeholders in

1 general. It could be employers. It could be hospitals,
2 physicians, patients, yeah (affirmative), it would be a broad
3 stakeholder meeting to convene to discuss it, then to see if
4 there's any consensus there. David, yeah (affirmative).

5 COMMISSIONER MORGAN: I think, to remember our
6 discussion, one of the things that we kind of coalesced around
7 was possibly, instead of doing one gigantic site with stuff
8 but there could be segments that -- like especially electives
9 or certain large-volume -- I think if you look at some of the
10 sites in the report, it wasn't a universal site with
11 everything.

12 There are certain segments, certain markets, certain
13 procedures that might lend itself better, especially on the
14 electives. The Alaska Health Care Underwriters sort of has an
15 unofficial one they developed because they do a lot of
16 comparison on electives, like hips and shoulders, and about
17 setting up -- they set up agreements to centers of excellence
18 in the Lower 48, which gives a little competition, but is very
19 cost effective.

20 I, actually, suppose it's more of a negotiating tool in
21 the state, too, but it's not necessarily all or nothing. It
22 could be different segments of the health care market,
23 especially in the elective areas or in certain groupings. I,
24 also, anecdotally and actually, inside my family yesterday,
25 which we have a new insurance policy, which has a higher

1 deductible, we -- my wife gets a yearly bill for a procedure
2 she gets done every year and I -- after I looked at it, which
3 it took me almost 35 minutes to even understand this statement
4 from the provider, I thought that was interesting.....

5 UNIDENTIFIED SPEAKER: If you can't understand it
6 (indiscernible - too far from microphone).....

7 COMMISSIONER MORGAN: Yeah (affirmative), right, but
8 after I got a calculator out and started going through it,
9 suddenly, my pay -- our pay-outs triple. Usually, we pay, out
10 of \$1,000, 80, \$90. This time, it's almost 300. Suddenly, my
11 wife is asking me, "Well, how can -- is there a way for us to
12 shop around on this elective procedure," she does once a year
13 now that she's past 29.

14 So the -- I think when we've had people come to the
15 Commission, if we all remember, that have been complaining
16 about on certain procedures virtually could not get
17 information. Now, that information might be out there and
18 they may need education, maybe even an inventory of where you
19 can get that information now through the insurance tools or
20 through the Federal Insurance Exchange, but I think we should
21 at least have it on the agenda.

22 We should be thinking about it and maybe looking at
23 Vermont and some other areas that are doing it, but in my own
24 mind, I've kind of come around to, especially the Alaska
25 Health Care Insurance Underwriters, we might even ask them to

1 come and talk about it a little bit, because they're doing
2 that now and have developed their own internal system, just
3 like Blue Cross and these other ones.

4 COMMISSIONER ENNIS: I think I would like to know what we
5 would hope to gain from a stakeholders' meeting, you know, as
6 we would plan it, there's going to be some effort to
7 coordinate and invite and announce, publicize it. I would
8 want to know if we have an idea already about the outcomes of
9 that meeting.

10 CHAIR HURLBURT: Jim, yeah (affirmative).

11 MR. PUCKETT: I think it would be too hasty to have an
12 all-stakeholders' meeting. I mean, we don't even have things
13 narrowed down among ourselves and if we were to want input
14 from stakeholders, we'd probably want to just get it from
15 specific types of stakeholders to help us form a final
16 definition of it, in other words, talk to providers separately
17 from private employers -- separate from other groups, in which
18 all that separate input -- then maybe we can narrow it down to
19 what is our goal, but I think if we try to have just a
20 stakeholder meeting with everybody coming in, that's going to
21 be -- that's going to be a challenge to try to manage.

22 MS. ERICKSON: We did hold a series of separate
23 stakeholder meetings, just as you're describing, Jim, when we
24 did the All-Payer Claims Database feasibility study and we had
25 once -- and the consultants facilitated those meetings and I

1 can't remember the exact questions, but they brought a series
2 of questions for each stakeholder group and providers were one
3 stakeholder group, insurers were another stakeholder group and
4 I don't remember how we had one for patients, maybe.

5 So we did do that once already around that and we could
6 or that was one of the things I'd hoped we would have time at
7 this meeting to spend a little time talking about what the
8 goals -- if we were going to have the stakeholder session,
9 what the goals would be, and I don't have strong feelings one
10 way or the other about a stakeholder session. So if the time
11 isn't right, that's fine.

12 I do have a suggestion, while I'm leaning toward feeling
13 relieved that it sounds like the group wants to wait, because
14 it's less work for me, but one thought, I'll just finish this
15 thought, one idea would be just an educational session to --
16 so not inviting input or feedback at this point to a
17 particular idea, but just kind of a learning, informational
18 session or a series of information sessions.

19 One way we did that in the past around patient-centered
20 medical homes was the webinar series we did and we invited, I
21 think, primarily providers, as stakeholders, to those sessions
22 and made them available over webinar and had identified three
23 patient-centered medical home programs from across the country
24 and Dr. Dobson in the North Carolina program was one example,
25 where we webinared and had folks participate that way, just as

1 learning sessions that wouldn't feel as threatening, for what
2 it's worth. Dr. Urata.

3 COMMISSIONER URATA: So this is a question for
4 legislators and Commissioner, are we thinking of having a bill
5 brought forward on this transparency issue for this next
6 session or not? Are we supposed to come forward with a
7 suggestion for that and if so, then we have a timeline that's
8 kind of limited, but if we're going to step back and say,
9 "Let's wait and see," then we don't need to necessarily worry
10 about it, but I thought we were -- I was under the impression
11 that we were going to try to bring something forward for the
12 Legislature this year.

13 REPRESENTATIVE KELLER: That wouldn't be at the
14 legislator -- Legislature's request, that I know of. That
15 would be something that would be initiating from this group.

16 CHAIR HURLBURT: Becky.

17 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
18 microphone).

19 SENATOR COGHILL: A bill can always come forward and so -
20 - and there's always interest in patients' rights and
21 responsibilities and with the Affordable Care Act, it's going
22 to create that dynamic, so -- because what's going to happen
23 is the -- your copays are going to go up on your private
24 insurance, requirements are going to be made by your ERISA
25 groups and the requirements are just going to go up.

1 That's going to start putting pressure on the price
2 sensitivity. In my view, though, until they start asking that
3 question, it's a top-down solution that is not well-defined
4 yet and so if you're going to do it and it's not well-defined
5 within the industry, you may not like what you get.

6 CHAIR HURLBURT: Senator Olson, I wonder if you have any
7 perspective on this to share?

8 SENATOR OLSON: Well, I think that certainly, as been
9 pointed out, that there has to be somebody with an interest
10 that's going to go ahead and push it. We can go ahead and --
11 those of us that have, you know, are into the health care
12 delivery system and have been part of it, can certainly push
13 it from that standpoint, but we also have to remember there's
14 an election coming up and with the election coming up, you may
15 have a different flavor of people that are there, because
16 there are, you know, at least in the Senate, we've got an
17 advanced nurse practitioner that's on, sometimes, with
18 (indiscernible) side of the issue and then, I'm the MD over on
19 the other side of the issue.

20 So there are -- is that tension that we can, if it's
21 engineered right, we can facilitate it and make sure it goes
22 through faster, but we could also hit snags over on the House
23 side, because you have a bigger body and you don't have the --
24 you don't have the people that have been hands-on over on that
25 side, like we have on the Senate side.

1 CHAIR HURLBURT: Commissioner, do you have any comments
2 or suggestions?

3 COMMISSIONER STREUR: No.

4 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
5 microphone).

6 CHAIR HURLBURT: Well, why -- why don't I really take
7 Allen's -- I'm sorry, Becky, yeah (affirmative).

8 COMMISSIONER HULTBERG: I just wanted to say that I, at
9 least, feel like my own knowledge base is incomplete when it
10 comes to state transparency laws. I know more about an All-
11 Payer Claims Database than I used to. So I feel fairly well,
12 you know, moderately educated on an All-Payer Claims Database,
13 but on our meeting discussion guide, you had a list of state
14 transparency laws.

15 I don't understand the implications of all of those laws,
16 what they would look like. Have they worked? Have they not
17 worked? So when we talk about transparency, I would feel, at
18 this point, equipped to talk about an All-Payer Claims
19 Database, sort of, but I feel completely unequipped to talk
20 about other state transparency laws, what they might look
21 like, if they had been effective, if they would work here.

22 CHAIR HURLBURT: Could I entertain a motion to not have a
23 stakeholder meeting? I think -- the reason I put it that way,
24 because that means neither information sharing nor the
25 decision-making, but to not ask our Executive Director to

1 schedule a meeting.

2 COMMISSIONER HIPPLER: Mr. Chairman, you can't make a
3 negative motion or you -- or you weren't making it. You were
4 asking someone to make it. Nobody can make a negative motion
5 like that.

6 UNIDENTIFIED SPEAKER: So (indiscernible - too far from
7 microphone).

8 COMMISSIONER MORGAN: Mr. Chairman, I move we table this.

9 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
10 microphone) motion to table.

11 COMMISSIONER HIPPLER: There's nothing to table.

12 UNIDENTIFIED SPEAKER: Just move on (indiscernible - too
13 far from microphone).

14 CHAIR HURLBURT: Okay, is there.....

15 MS. ERICKSON: Wait, I -- we're -- I.....

16 CHAIR HURLBURT: Is there a motion? I don't see a
17 motion.

18 COMMISSIONER HIPPLER: Mr. Chairman, do you want me to
19 make a motion and then have it fail? I can do that for the
20 record, if that's what you want, but otherwise, we just move
21 on.

22 CHAIR HURLBURT: I'm fine with moving on. I think the
23 consensus is clear. Okay, we're nearing -- getting close to
24 the end of our time. I want to ask the usual question, is
25 there anything else we need to cover now?

1 MS. ERICKSON: No.

2 CHAIR HURLBURT: Yeah (affirmative).

3 MS. ERICKSON: Well, did.....

4 CHAIR HURLBURT: That's.....

5 MS. ERICKSON: You know what, I do -- I mean, I -- for
6 your homework, I asked if you had any questions for the three
7 learning sessions we're planning on having at the next
8 meeting, to bring those to this meeting. We could do that
9 over email, unless anybody has a burning desire, except the
10 one thing that I really want to talk -- we'll have more time.

11 If we're not going to talk about transparency in the
12 fall, we'll have more time to talk about clinical quality and
13 one thing that I really wanted to hear back, and I know Dr.
14 Urata had some ideas at one point, so maybe we just have that
15 conversation separately online.

16 Do you all have the energy left to talk about a learning
17 session on clinical quality improvement or are we fried from
18 the past two days?

19 COMMISSIONER URATA: Do you have any ice cream?

20 MS. ERICKSON: Do we have ice cream? We -- well, a big
21 thank you to Barb for bringing brownies and cookies this
22 afternoon.

23 UNIDENTIFIED SPEAKER: Yeah (affirmative).

24 MS. ERICKSON: After just giving us vegetables yesterday
25 afternoon, but that was my fault.

1 CHAIR HURLBURT: And Deb, on the transparency, at least
2 what I thought I heard, was that this group wants to continue
3 to educate ourselves on it, but that we did not think the time
4 was right to bring a larger stakeholder group together, since
5 we have enough confusion in our own minds, but that we feel
6 it's an important issue for us to continue.

7 How that fits in, that's not being specified. It doesn't
8 have to be the next meeting, but we're not just dropping it as
9 a topic for the Commission.

10 MS. ERICKSON: Yeah (affirmative), I -- and I get that.
11 I guess I want to -- now, I can't remember who asked the
12 question. Was it Becky? Who asked the question of the
13 legislators if there's some legislation that's about to be
14 dropped?

15 COMMISSIONER URATA: I did.

16 MS. ERICKSON: Dr. Urata. I just wanted to go back and
17 you weren't with us at our March meeting when we started this
18 conversation about what we're producing, what we're doing as
19 far as being a convener for -- evolving into that role and
20 producing more detail and we haven't gotten into details on
21 these policy recommendations in the past because it was too
22 much detail for a group this large with this diverse a
23 knowledge and perspective base to start getting into those
24 more operational weeds.

25 The reason I brought the Draft All-Payer Claims Database

1 Legislative Elements paper forward was that a legislator, we
2 are not going to say who, I will not say who, drafted All-
3 Payer Claims Database legislation this last session and
4 brought it to me and said, "Look at this. We're going to do
5 this," and I went, "Oh."

6 So -- and what -- and I thought, since this group, I
7 mean, the recommendations coming out of this body are getting
8 more attention. There are employers interested in working
9 directly with legislators and with the Governor's Office on
10 developing legislation based on recommendations from this
11 Commission.

12 So the question, again, is, do you want to have a public
13 process and do you want to provide more guidance, because it's
14 going to happen. It's happening already. It's going to
15 happen. Do we have the bandwidth, do you all have the time to
16 learn and spend and do you want to be the convener of
17 stakeholders to have a broader discussion or do we just let it
18 happen and watch, like we, essentially, did with the Hospital
19 Discharge Database? It's so far coming out the way -- so --
20 so that's.....

21 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
22 microphone).

23 MS. ERICKSON: No, (indiscernible) we said it in March
24 and I said it at the beginning of this meeting yesterday.

25 UNIDENTIFIED SPEAKER: And that's what I was trying to

1 say with a table and menu (indiscernible).

2 MS. ERICKSON: So I mean, it's -- I mean, it is what it
3 is. I mean, I don't mean it to sound like a threat, if folks
4 are feeling that way and taking it that way. It feels as
5 though it's too -- it's too much for this group to address
6 that level of detail at this point.

7 We're putting the general policy recommendations out.
8 What I would tell folks who wanted the Commission to do more
9 with stakeholders, over the past couple or three years, was
10 that we were trying to identify -- this group was working to
11 identify the -- what state -- what the state needed to do, not
12 how to do it, because we didn't have the bandwidth, but we
13 were trying to be a separate, independent, almost like an
14 Institute of Medicine Study Group, where we would look at what
15 the best thing for Alaska was, from a real high level, policy
16 level, and come up with those recommendations and then let the
17 public process take over from there and the policy leaders
18 would have to implement, develop and implement the operational
19 piece, decide how to do it.

20 So we were doing very high level, what the state should
21 do, and then let, through the public process, whether it's
22 through the legislative sausage-making machine, the state
23 agency heads and the Governor's staff figuring out how to do
24 things at the ground level, and that we were letting go of it
25 from there.

1 So that's kind of where we're at in our evolution of what
2 the Commission's role is that -- is figuring out if we're --
3 if we're going to get more detailed or not, if we're just
4 going to stay back and work on the general strategies .

5 COMMISSIONER URATA: So we've already accomplished that
6 with the All-Payer Claims Database. The only thing is, you
7 know, this report from HFMA on price transparency, you know, I
8 guess I would endorse that, but I think whoever takes this up
9 will already know about this, so we don't really need to say
10 anything about it. So we've done our job on transparency. Is
11 that what I heard you say?

12 MS. ERICKSON: Maybe. It -- I mean, it -- or it depends.
13 We have done a job on transparency. I mean, we've identified
14 three -- we've identified three policy recommendations at a
15 very high level that are, again, are more at the what level,
16 not the how level.

17 One of those recommendations, the Commissioner has
18 already implemented, essentially, and he's figuring out what -
19 - how to do it and he's doing it. The other two, legislators
20 are either going to take or they're not, because those other
21 two need to be implemented by legislators. So they're either
22 going to take them or not, and as Senator Coghill suggested a
23 few minutes ago, if we don't get into the finer details, we
24 may or may not like what comes out of the legislative process,
25 but it's going to happen, whether it happens this winter or a

1 couple of legislative sessions from now. I expect it will
2 happen, so.....

3 COMMISSIONER URATA: And then there's no good model out
4 there (indiscernible - too far from microphone).....

5 SENATOR COGHILL: And just in self-defense, the
6 Legislature is also a significant convener and this body would
7 be able to, at least, be part of that convening and I would
8 expect that it could be deliberative, but there have been
9 opportunities where things have gotten through the Legislature
10 without a lot of review.

11 So that would be the danger of not being able to say --
12 either dissect it into pieces. Here are the first things or
13 here are things that are not acceptable from a top-down
14 perspective to the industry. I mean, you have those
15 parameters on here's what's doable for whatever, for patients,
16 for business. Here is the diminishing return on an investment
17 level, where a lot of work and no return comes in, maybe that
18 kind of a perspective .

19 I started seeing that a little bit in some of the reading
20 that I got, but I'm certainly not comfortable and I don't know
21 if, after listening to the discussion here, if we could get
22 that out of an industry. I just don't know that.

23 COMMISSIONER HULTBERG: I just suggest that at a future
24 date, there are two things we could put on this group's
25 agenda. One would be to have examples of what the private

1 sector is doing. So what's Premera doing? What's Aetna
2 doing? What's, you know, MODA doing? You know, what are the
3 tools out there that the private sector is using and
4 understand those at a deeper level.

5 The other thing we could do is look at what state
6 transparency -- what state transparency laws exist on the
7 books in other states. The Catalyst for Payment Reform has
8 them -- has -- identifies what they are, but I don't really
9 understand much about the mechanics of them, how -- have they
10 worked, have they not? So there are two other areas that --
11 of opportunity, I think, for us to learn a little bit more
12 about this beyond the All-Payer Claims Database.

13 CHAIR HURLBURT: We did have the contract with the
14 Freedman Group out of Boston, what, a couple of years ago now,
15 that updated the situation, I think, for much of what you're
16 talking about. From my bias, it was one of our less
17 successful contracts. So I don't think we would want to go
18 back to them for an update, but I think the situation is
19 dynamic.

20 So an updating of that information exactly as you
21 described of what's happening elsewhere, we don't have to be -
22 - we're not going to be the early adopter with 11 states
23 having it now, but I think I have heard a number of
24 suggestions of let's wait.

25 I guess in my own mind, this is another case where,

1 initially, I was more enthusiastic to go ahead because,
2 conceptually, I think it sounds good, but I've moved more in
3 the direction of my boss' bias where, I think, Bill has been a
4 little more of, "Well, good idea, but maybe later, maybe we're
5 not quite ready." Yes, Becky.

6 COMMISSIONER HULTBERG: I was just going to say, and I'd
7 mentioned the insurers, but I think there are other -- it's --
8 when I say, "private sector", it's not just insurers. It's --
9 it could be providers. What are some providers voluntarily
10 doing now?

11 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
12 microphone).

13 COMMISSIONER HULTBERG: Yeah (affirmative), Castlight,
14 you know, as a vendor, so there's a lot out there that I think
15 might help inform the conversation from the private sector and
16 not just on the insurer side.

17 CHAIR HURLBURT: Bob, please.

18 COMMISSIONER URATA: So more education until a lightbulb
19 goes on.

20 CHAIR HURLBURT: Okay, yeah (affirmative).

21 MS. ERICKSON: Can we talk about -- can we talk about
22 clinical quality learning session ideas for October and then
23 wrap up with evaluation of this meeting? Does that sound
24 good? Dr. Urata, did you have some specific suggestions of
25 what we might do for a learning session on clinical quality

1 improvement?

2 COMMISSIONER URATA: Well, I'd like to hear from, you
3 know, I'll throw this out. So there are hospitals that have
4 been very successful in improving their quality through
5 different processes. Although, some of the processes, to me,
6 are very burdensome, but as a result, a higher quality of care
7 -- I think it translates to lower costs and prices and so I'd
8 like to hear from them and then try to figure out if there's a
9 connection to clinics and how would clinics do that, and I
10 haven't heard from clinics and then -- or rural area clinics,
11 in particular, how do they go through this process and.....

12 MS. ERICKSON: Do you have some specific examples?

13 COMMISSIONER URATA: Well, I understand Virginia Mason
14 has done that, but they're very complicated because they did
15 learn the Toyota method. They sent people to Japan to do it,
16 but clearly, I'm -- other hospitals have done it and I don't
17 know if they've gone through such an intense program like they
18 have, but I'm not sure.

19 MS. ERICKSON: Becky, do you think -- is that something
20 that you think you could help us with is identifying hospitals
21 in Alaska that might be working on some of those initiatives
22 and then some models outside?

23 COMMISSIONER HULTBERG: I'm sure I can -- we can help
24 with that and there are probably a couple of different
25 approaches we can take. I mean, there are some things

1 individuals, any of -- the hospital CEO sitting in the
2 audience right now, who I'm sure could talk to you about, you
3 know, what her facility is doing in terms of quality.

4 There are efforts at individual facilities. Then, there
5 are some collaborative efforts. The Partnership for Patients'
6 Initiative through CMS, which is ending this December, but has
7 been an effort where -- through sort of groups of -- groups of
8 hospitals called Health Engagement Networks have made -- have
9 targeted specific quality indicators and have looked at
10 establishing baseline data, which is a -- which is not an easy
11 thing to do.

12 I mean, you think it's easy to establish baseline data,
13 but if you're measuring something like patient falls, how are
14 you measuring it, because if you're not all measuring it the
15 same way, you can't -- you don't have a basis of comparison,
16 so establishing baseline data and then looking at how the
17 organizations can -- the facilities can individually improve
18 and it's really demonstrated, nationally, some really good
19 results in terms of cost savings.

20 We started a little bit late and so we're not quite there
21 in terms of demonstrating that, but I think it's a good -- it
22 might be something interesting for this group to learn more
23 about and then we can maybe look at some of those facility-by-
24 facility things that are happening, as well.

25 COMMISSIONER URATA: So I think, you know, we all

1 understand that quality is good, but what are the key things
2 that work, because I'd like to see, you know, outcomes of
3 this, not just, we're doing this and doing that, and -- I want
4 to see the outcomes and the savings or the elimination of
5 waste and I'm not so sure that there's a lot of facilities
6 that can prove that and I think it would be -- well, yeah
7 (affirmative), I don't want to argue with you right now, but
8 anyway, I think it's important.

9 CHAIR HURLBURT: Allen.

10 COMMISSIONER HIPPLER: So maybe I'm just tired and more
11 grumpy than usual, but when we're having this discussion about
12 quality, I feel like we're pushing a string, instead of
13 pulling it. I feel like the chances for reform are involved
14 with evidence-based medicine on the payer end, on the back-
15 end, where you can enforce it and I'm not quite sure what this
16 Commission would do, as far as quality. What are we supposed
17 to -- I'm not sure what our goal here is. I don't get it.

18 COMMISSIONER URATA: So my big puzzle, everybody says,
19 "Quality is important. It saves money," but I want to know
20 how. What does that look like, because I'm not so sure that
21 the stuff that I'm supposed to be doing works, because I don't
22 know the outcomes are the way they're supposed to be.

23 I understand that Virginia Mason has gotten a lot of
24 awards and I understand that their prices are down and so
25 they're supposed to be an example of how quality has improved

1 care and eliminated waste and -- but I think that the way that
2 they did it, was very intense and very expensive and so, are
3 there other programs out there that are as successful for
4 reducing waste and improving quality and thereby, they're able
5 to cut down on their prices, because otherwise, you know, this
6 quality and transparency and stuff is worthless.

7 CHAIR HURLBURT: Becky.

8 COMMISSIONER HULTBERG: I think Dr. Urata raises some
9 really good points and I'm -- I mean, I don't want to put
10 Julie on the spot, but she lives this, I mean, she's a
11 hospital CEO. So I just wondered if maybe it would be
12 valuable to hear her perspective? So if you're.....

13 MS. TAYLOR: I can give you a two-minute rendition, if
14 you want it?

15 CHAIR HURLBURT: Sure.

16 MS. TAYLOR: Do you want me just to sit here and.....

17 UNIDENTIFIED SPEAKER: No, you need to come turn on a
18 mic.

19 UNIDENTIFIED SPEAKER: Push the green button.

20 UNIDENTIFIED SPEAKER: And introduce yourself, please.

21 MS. TAYLOR: My name's Julie Taylor. I'm the CEO of
22 Alaska Regional, and yes, I live this every single day.
23 There's some real purposeful things that we are doing to
24 reduce costs and one example would be reduction in ventilator
25 days and you use quality things that you can do to reduce the

1 number of days on ventilators, which reduces complications and
2 subsequently, costs.

3 There's the core measures efforts that we put in place to
4 make sure the antibiotics are used appropriately and are
5 effective and people are, you know, get out of the hospital
6 quicker. There's also removing urinary catheters, timing, all
7 those things, but there's also looking at discharge planning
8 from day one, and can you reduce the length of stay?

9 You know, it's interesting you bring up Virginia Mason,
10 as they were just at Alaska Regional this week. I invited
11 them up and -- because I had been down to their facility, too,
12 because I'm very interested in what they have to offer and
13 they have programs that are wonderful and much like what we do
14 with HCA.

15 You know, we're part of 166-hospital system. So we have
16 a lot of talent that we're able to share and I think that
17 there's things that we could learn from each other on that
18 agenda. So I would say, "Absolutely, there's very measurable
19 things."

20 CHAIR HURLBURT: I guess, the bias I have is, as I think
21 about quality, probably in the current role that I'm in and
22 that I've been in the last few years, the focus is on doing
23 the right thing for the right patient, the right place, the
24 right time, and that's evidence-based decision-making,
25 benefits to coverage and clinical decision-making, but then,

1 quality, also, I think, is more what we're talking about now,
2 and that's the kind of thing that the Institute for Health
3 Care Improvement has been involved in and that's also quality,
4 but in my mind, it's a little differently but when I've got a
5 hospital administrator's hat on or a surgeon's hat on, that
6 was the kind of quality that I was, you know, focused on then
7 and I think that's what we're talking about now and I would
8 say that we, at least, want to look at -- if we're talking
9 about that kind of quality, what IHI has.

10 A lot of people in Alaska have been involved in that. If
11 he hadn't decided to be -- try to be a Democratic candidate
12 for Governor of Massachusetts, we probably could have even
13 gotten Don Berwick up here, as much as he likes Alaska, but
14 he's excluded himself until he gets over that compulsion,
15 but.....

16 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
17 microphone).

18 CHAIR HURLBURT: Yeah (affirmative), yeah (affirmative).

19 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
20 microphone).

21 CHAIR HURLBURT: Yeah (affirmative).

22 COMMISSIONER MORGAN: We also have -- we could -- on the
23 clinic side, Dr. Tierney at Southcentral has done a lot of
24 this kind of stuff with his group. Since I'm not -- since I
25 don't work there anymore, I could -- it's not boasting, but

1 they did get the Baldrige, the National Baldrige Award for
2 this kind of stuff, but it was for the primary care side, the
3 clinic side.

4 Dr. Eby might, unless we're wanting to schedule a three-
5 day meeting, I don't, but I would -- but Dr. Tierney, who's
6 the guy in charge of improvement and quality for -- that works
7 for Dr. Eby would be -- if you wanted to keep it to an hour-
8 and-a-half with eight slides, I think that would be who I
9 would invite, but a full day with Dr. Eby would be okay with
10 me, if you want.

11 CHAIR HURLBURT: So what I'm hearing is there's interest.
12 We have some local expertise, potentially, Julie. There might
13 be some resources from HCA that could share with us, either in
14 person or on a web such as we had with Dr. Grundy today, that,
15 excuse me, Southcentral has gotten a lot of international
16 attention about their Nuka Program and some of the things that
17 they've done there, but -- but it is -- yes, does that kind of
18 give you enough to run with that?

19 MS. ERICKSON: I will -- I -- yeah (affirmative).

20 COMMISSIONER MORGAN: We'll put this under self-help.

21 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
22 microphone).

23 MS. ERICKSON: Thank you.

24 CHAIR HURLBURT: Thank you very much, Julie.

25 MS. ERICKSON: Thank you, Julie.

1 CHAIR HURLBURT: Thank you for being here with us. Okay,
2 what went well, what didn't go so well, what could be better
3 about this?

4 MS. ERICKSON: Yeah (affirmative), let's break it up, and
5 first, if you would share what you liked best about the
6 meeting in the last couple of days and then we'll -- then
7 later, we'll talk about what you wish would be better next
8 time. So first, what did you like about the meeting in the
9 last couple of days?

10 COMMISSIONER CAMPBELL: Lunch.

11 CHAIR HURLBURT: More substantive discussions .

12 COMMISSIONER URATA: I liked the fraud and abuse part.

13 MS. ERICKSON: What did you like about the fraud and
14 abuse part?

15 COMMISSIONER URATA: It caught my interest. I thought it
16 was very interesting to see, you know, how it works and the
17 people involved.

18 CHAIR HURLBURT: Yes.

19 COMMISSIONER ENNIS: I enjoyed the review of the Employer
20 Health Benefit Survey. I was impressed at the scope of
21 information that we were able to gain from the report on the
22 results of the survey.

23 CHAIR HURLBURT: Bob, yeah (affirmative).

24 COMMISSIONER URATA: I like Jeff's presentation.

25 COMMISSIONER DAVIS: I liked sitting next to Becky,

1 getting a plaque and having people say really nice things that
2 I don't deserve. So thank you.

3 CHAIR HURLBURT: Anything else?

4 MS. ERICKSON: Suggestions for improvement, what could
5 work better next time?

6 CHAIR HURLBURT: Jim.

7 MR. PUCKETT: Ice cream, that will be late in the day.

8 CHAIR HURLBURT: Allen.

9 COMMISSIONER HIPPLER: Okay, we had the Special
10 Investigations Unit at Aetna present and I thought that a lot
11 of the presentation wasn't really Alaska-focused and I didn't
12 find it -- looking back on it, I don't feel that the
13 Commission gained a lot of information out of that.

14 CHAIR HURLBURT: What else? Other things that were not
15 of high value or that could be done in a better way?

16 MR. PUCKETT: There'd been times where you've asked us,
17 as a group as a whole, to identify a question and I wonder if
18 it would be better time served if you and Debbie came up with
19 some questions, several, for us to talk about and decide on,
20 instead of looking at a group of this size to try to narrow
21 down a question for us to pursue.

22 I think it might be better if the two of you or maybe
23 engage one or two of us in an email exchange and come up with,
24 say three questions or three forms of a topic that you want us
25 to pursue that we could decide on which topics or which

1 version of the topic we would use.

2 I felt a little bit at a loss when we were trying to
3 determine a question, how to word a question, when we were
4 doing it as a group.

5 CHAIR HURLBURT: Jeff.

6 MS. ERICKSON: Wait, wait, I just want to clarify, was
7 there a specific area, a specific part of the conversation
8 over the last day-and-a-half?

9 MR. PUCKETT: Yeah (affirmative), yesterday, I think, the
10 time is kind of running together for me on this second day of
11 the meeting, but yesterday, it was early afternoon, I believe,
12 or maybe it was later in the morning, maybe mid-day.

13 MS. ERICKSON: Was it -- was it -- and the reason I want
14 to know is because it will help me facilitate better next
15 time.

16 MR. PUCKETT: No, I understand.

17 MS. ERICKSON: So I need to understand exactly what was -
18 - was it around the employer conversation or transparency
19 conversation yesterday?

20 MR. PUCKETT: The -- it was transparency.

21 MS. ERICKSON: It was transparency?

22 MR. PUCKETT: Yeah (affirmative), you.....

23 MS. ERICKSON: And I think -- I mean, we talked about
24 that this morning, Dr. Urata and I did on a sidebar, because
25 that's why I got a little -- way more focused this morning

1 with the shorter time and decided afterwards, allowed too much
2 free-flowing -- thought, really, had identified three
3 questions I thought I was asking, but allowed way too much, I
4 think, free-flowing discussion around those three questions
5 and so, to your point, Jim, and thanks for letting me ask some
6 more questions, because I wanted to -- that just verifies --
7 we'll work on focusing, when we have more time for more open
8 discussion, focusing the discussion a little bit more. So
9 thanks.

10 MR. PUCKETT: I appreciate your deference because you're
11 looking for input from us, but I think it just helps us, as a
12 group, if you do give us a little bit more specific direction.

13 COMMISSIONER URATA: I think you do a wonderful job,
14 nevertheless.

15 CHAIR HURLBURT: Jeff.

16 COMMISSIONER DAVIS: Absolutely ditto on the Deb does a
17 wonderful job and so does Ward. I -- just to caveat this
18 public policy discussions like this, public bodies, there's a
19 certain amount of pain inherent, all right, and wondering
20 around that's got to happen, but I think, Deb, in the
21 transparency discussion, maybe just a slightly different take
22 on what -- Jim's observation, when Becky asked yesterday, you
23 know, what's our objective here, because we were having a
24 little sidebar about that, and so in the same way, having, you
25 know, some more clarity about what questions we're trying to

1 answer, maybe in some cases, that is the objective, is
2 answering some questions, but other times, there's another
3 broader objective, and in the same spirit of my comments about
4 the stakeholder group, agreeing with Jim, in a group this
5 size, having more clarity about what that is and then mashing
6 that around, rather than starting from scratch, I think is
7 very helpful.

8 So thank you, and I'm not so sure about two full days and
9 I'm not trying to be facetious, but that's a long time in a
10 group like this to keep your head in the game, but I won't be
11 around. So if you want to meet for three days, that's fine,
12 but I'm just not sure about that.

13 CHAIR HURLBURT: Yeah (affirmative), before Larry left,
14 Larry had -- he said a very strong plea to go back to a day-
15 and-a-half. I think right now, he's probably the most
16 impacted, since -- for Bob to come up, it kind of consumers
17 two days for you anyway, whether it's a day-and-a-half or two
18 days, but as a clinician who's closer to his clinical
19 practice, he had patients waiting today.

20 He was called out yesterday. He said that a day-and-a-
21 half does help him to accommodate that and I think that having
22 the active clinicians here, as a part of the team with Bob and
23 Larry, is a very important perspective to us and although, you
24 know, folks like myself, we get our salary, and then most of
25 us do, that we need that perspective. So that was Larry's

1 plea, more strongly than you stated it, yeah (affirmative).

2 MS. ERICKSON: Any other suggestions for improvement,
3 wishes for next time? Okay, well, do you want to have the
4 final word and wrap up?

5 CHAIR HURLBURT: I think that's it. Thank you, all, for
6 being here. Jeff, godspeed and thank you for all you've done.
7 Becky, thank you for being willing to come on the Commission.
8 So see you next time.

9 4:32:59

10 (Off record)

11 **END OF PROCEEDINGS**

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