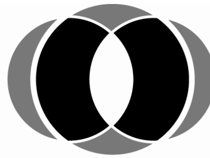

HEALTH CARE ACTION GROUP
AUGUST 20, 2009
Alaska Native Tribal Health Consortium
MINUTES

1. **CALL TO ORDER:** Meeting was called to order at 7:05am by Co-chairs Duane Heyman and Tom Nighswander

   Members/Guests Present: Brian Richardson, Matt Dupre, Regan Mattingly, Deb Erickson, Cathy Giessel, Randi Sweet, Pat Luby, Carl Ekstrom, Jenny Miller, David Driscoll, Jeff Ranf, Elizabeth Ripley, Mark Foster, Nancy Merriman

   Staff Members Present: Josh Wilson

2. **Denali Commission Health Facilities Program Update – Nancy Merriman**
   - Health Facilities Program
     - Senator Stevens founded the Denali Commission Health Facilities Program 10 years ago after realizing the very real healthcare needs in rural Alaska
     - It was designed to be a federal/state cooperative with very low overhead cost (5%)
     - In 1999, enlarged the program to help build health care facilities
     - Now behavioral health, dental, senior care, and emergence care have also been included in the program
     - Have identified 40 million dollars of need for construction cost a year
     - Health facilities program is 32% of the whole Denali Commission program
     - Priority on local labor, training, and construction of the clinics
     - Facilities are staffed with community health practitioners or health aids
   - Stimulus
     - The Alaska Health Clearing House identifies entities who are eligible for Recovery Act Funds – the Legislature supported this process
     - 142 Community Health Centers / access points in Alaska where over 81,000 people are treated
     - Formula based funds for patient load
     - Health Information Technology is woven throughout the contract to address the clinics' technological infrastructure needs
     - Grant applications for Health Care and other industries closes in October
     - There may be money for health professional training
     - Energy an important effort with the Recovery Act
     - The Denali Commission offered match funds for renewable energy projects in rural Alaska

    - Not sure on the status of the new energy money the Legislature just accepted
- Clinics
    - FEMA may replace the Eagle Clinic that was completely destroyed
    - Close connections with regional health groups
    - Operations and sustainability doing well, but want to make sure clinics are being built the right size
        - Too big is bad because it is hard for the community to maintain utilities
    - Staff retention is much easier when you have a nice facility to go to
    - Looking to improve designs of clinics for better functionality/upkeep

3. **ISER Report on Medicare - Mark Foster**
- There are 50,000 people statewide on Medicare
- In the study polled 240 physicians in Alaska
    - In Anchorage only 20% of doctors are taking new Medicare patients
    - Statewide about 90% of doctors are seeing new Medicare patients so this is a Anchorage based problem
    - 10 states are having big problems with Medicare (OR, UT, CO, NM, AK, TX, ID, OK, WA, CA
    - Most states do not seem to be having a problem
- When polled most doctors said these were the top problems with Medicare patients
    - 98% Reimbursement
    - 80% Billing
    - 70% Patient more complicated
    - 50% Audit concerns
- Alaska is about 20% higher than the rest of the nation on the above questions, there is a higher sensitivity here
- Medicare reimbursement problems have mostly effected primary care physicians
- Reform – the main thing to watch is how will it affect us relative to other states
    - If it disproportionally effects states you could see patients and doctors move their current locations for better benefits somewhere else

4. **Outmigration Report - Institute of Circumpolar Health Studies at UAA – Jenny Miller**
- Beginning a study on the causes of outmigration on health care
- 2 components of the study
    - Informative review of published literature and community organization work
    - Will speak with individuals who have moved here from rural areas to see why they have moved and if health concerns were a factor
    - Timeline – hope to be finished by April

5. **Private Co-op Model as an alternative to improve health care – Pat Luby**
- There are many co-ops, they are typically non-profit, member owned, and are voluntary to join
- Not run by government
- Senator Conrad from North Dakota was the first to introduce this idea
- Co-op would have an exchange of information, not only co-op info but other private insurance companies information as well
    - Theory is information would be more evident
- Non-profit does not mean non-profitable

    - Idea is that for-profit insurance would then make prices more competitive
- Government would have to put 3-6 Billion into the program to get it started
- Co-op would have to have cash reserves
    - Products available to everyone
    - Premiums regulated
- In Massachusetts the cost was higher than expected and there were not enough providers
- Theory is you would create more job mobility as well because people would not be stuck to jobs with good health care plans, they would take their health care plans with them
- Would need at last 500,000 people involved to take it financially viable
- Have historically had some co-ops that worked
    - Minnesota and Seattle, but many small ones have failed
    - Successful ones are run on about a 2% margin
- Problem is Co-op would have to be open to people with pre-existing conditions

6. **Adjourned: 9:00am**

7. **Next Meeting: September 17th, 7-9am location TBA**

Note: Meetings will be every 3rd Thursday from 7-9am