ALASKA STATE LEGISLATURE
JOINT MEETING
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 17, 2009
3:11 p.m.

MEMBERS PRESENT

SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Senator Bettye Davis, Chair
Senator Joe Thomas
Senator Fred Dyson

HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Representative Bob Herron, Co-Chair
Representative Wes Keller, Co-Chair
Representative John Coghill
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes
Representative Bob Lynn

MEMBERS ABSENT

SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Senator Joe Paskvan, Vice Chair
Senator Johnny Ellis

HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

All members present

COMMITTEE CALENDAR

Presentation: U.S. Preventive Medicine
HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record.

WITNESS REGISTER

FRED GOLDSTEIN, President
U.S. Preventive Medicine, Inc. (USPM)
Jacksonville, FL,
POSITION STATEMENT: Presented USPM's medical care management programs and services.

ACTION NARRATIVE

3:11:07 PM
CHAIR WES KELLER called the joint meeting of the Senate and House Health and Social Services Standing Committees to order at 3:11 p.m. Present at the call to order were Representatives Cissna, Seaton, Herron, Coghill, Holmes and Keller.

Prevention - a Concept for State Medicaid Programs

CHAIR KELLER announced a presentation by Mr. Fred Goldstein of U.S. Preventive Medicine, Inc. regarding their innovative approach to preventive health care. Mr. Goldstein served as the founder and President of Specialty Disease Management Services, Inc. and Vice President/General Manager of HealthCare USA and has more than 25 years of experience as a health care executive managing hospitals and disease-management programs.

SENATOR DAVIS joined the meeting.

3:13:05 PM
FRED GOLDSTEIN, President, U.S. Preventive Medicine, Inc. (USPM), Jacksonville, FL, invited the members to ask questions while he works his way through his slide presentation.

3:13:39 PM
SENATOR DYSON joined the meeting.

MR. GOLDSTEIN said USPM brings together people with extensive backgrounds in health plans, hospital management, chronic care management, Medicaid programs and commercial programs; they have over ten years of Medicaid care management experience working in rural states. They have worked in excess of ten states and over 14 programs in the Medicaid arena, managing everything from diabetes to HIV/AIDS and sickle cell disease. That experience includes diverse populations and over 60 different primary languages; they have worked in very remote communities as well as in urban areas and have experience working with Native Americans. USPM currently has national services available and is setting up an international service opening in the United Kingdom in April.

Prevention is their only business. As a company, they walk the walk and live prevention in their workforce around the country; each one of them feels he is on a mission to create real change in the health care system and to help individuals improve their long-term health. Their slogan is "more good years."

3:15:16 PM
Why prevention? The answer is found in a systematic approach that identifies current and future risks based on key clinical indicators. The program is clinically based and built upon clinical metrics to identify individuals' risk factors; they believe it is important to intervene with effective programs based upon those factors, to change individuals' behavior and provide them with care-management skills. It is also important to periodically measure results and seek to reduce overall health care costs including those associated with not only medical care, but with absenteeism and loss of employee productivity.

MR. GOLDSTEIN said Governor Tommy Thompson, former Secretary of Health and Human Services for the United States, is U.S. Preventive Medicine's National Policy Advisor. He presented a short video of Governor Thompson talking about the results of a study he conducted as Secretary of Health, into the health care needs of all Americans and opportunities to change the country's health care system for the better. He found three things that need to be addressed to improve the quality of health of all Americans are: disease management, prevention and early detection. U.S. Preventive Medicine, Inc. is bringing those principles together and incorporating them into a business model that they will take to the United States and the world. Their business is based upon finding individuals who need help to improve their quality of health and using early detection and prevention methods that really work in order to manage disease in those individuals who need it. This is a bipartisan effort that he believes will be able to transform the health care system of America.

3:17:47 PM
MR. GOLDSTEIN also presented a video clip of Tom Daschle, leader of the transition health care policy team for then President-elect Obama, and Lauren Aronson, responding to public comments about health care that were submitted on "change.gov". The first comment they addressed was that all Americans would benefit from a shift in health care that emphasizes prevention and addresses the causes of illness over treatment of symptoms. Other comments

and suggestions included formation of a “health corp.” rather like the peace corp., so that finishing medical students can give back to their communities.

MR. GOLDSTEIN added that this really is a bipartisan issue and recent discussions in Washington D.C. have made it clear to him that prevention is finally on the radar for this country and should be for the state.

He offered a clinical definition of the word prevention according to the American College of Preventive Medicine, the American Medical Association and others.

- Primary prevention includes those things you do to keep healthy such as eating well, wearing seatbelts and not smoking.
- Secondary prevention is early detection, or identifying individuals who are at risk for something but don’t yet have any symptoms.
- Tertiary prevention is chronic care management, making sure that people with chronic problems such as diabetes, heart disease and schizophrenia are treated appropriately and follow through with their treatment.

3:20:27 PM
He explained that USPM has a suite of services that create a complete wellness program called the Prevention Plan. They also have a Chronic Care Management Program which is added to the Prevention Plan in their Prevention Plan Plus, and the Prevention Plan Premium, which incorporates advanced diagnostic and assessment programs.

3:21:24 PM
MR. GOLDSTEIN presented another video that used a car maintenance analogy to describe their prevention plan.

3:22:29 PM
He said USPM works with a number of important diseases including heart failures, diabetes, asthma and chronic obstructive pulmonary disease (COPD). Chronic disease is the number one cause of death and disability in the United States; 133 million Americans representing 45 percent of the population have at least one chronic disease. Chronic conditions kill over 1.7 million Americans annually and are responsible for seven out of ten deaths in the United States.

Individuals with chronic disease account for 75 percent of America’s total health care spending. During 2005 the country

spent almost $2 trillion; that is now $2.3 trillion and the number is projected to grow every year. In the public sector, $0.96 of every Medicare dollar and $0.83 of every Medicaid dollar are spent on chronic disease.

3:23:28 PM
As the CDC [Center for Disease Control] said, the United States cannot address escalating health care costs unless it begins to look for ways to mitigate the issue of chronic disease.

MR. GOLDSTEIN continued; during the period from 1987 to 2000, 2/3 of the $313 billion increase in health care costs was due to an increased prevalence of people with chronic disease. They are now seeing an increase in what used to be called "adult onset" diabetes in children and a recently released study showed individuals 12 years old with cardiac systems that look like those of persons 35 years old. Obesity is a nationwide problem; he displayed a map representing information on body mass index (BMI) by state. From 1987 to 2005 the number of people with a BMI over 30 (30 pounds over weight) doubled and the obesity rate in children has tripled since 1980. Alaska is in the 25 to 29 percent range. These increases account for a 30 percent increase in health care spending. If the presence of obesity was the same today as it was in 1987, our health care costs would be approximately $200 billion lower.

U.S. Preventive Medicine has also found that the vast majority of chronic diseases could be better managed or prevented. The CDC says that 80 percent of heart disease and strokes, 80 percent of type two diabetes and 40 percent of cancers could be prevented if people would do three things: stop smoking, eat healthy and get in shape. Studies by The Institute of Medicine and others have found that those who are chronically ill only receive 56 percent of the clinically recommended preventive care; so when they visit the doctor, they are not getting all of the services they should.

3:26:19 PM
The health care system is set up to treat illness instead of prevent it; typically, people can't get services unless they have symptoms. The system is also very fragmented, with superficial programs that bring in only 7 to 12 percent participation. It has been unsuccessful in changing behavior as there are few, if any, meaningful incentives for individuals to make the kind of behavior changes necessary to improve their health.

MR. GOLDSTEIN said the Milken Institute released a study in 2007 titled "An Unhealthy America: The Economic Burden of Chronic Disease" which found that if the U.S. started practicing prevention, early detection and chronic condition management, the impact on the U.S. economy by the year 2023 would be in excess of $1 trillion annually. This is $1 trillion a year that could be saved.

3:27:49 PM
MR. GOLDSTEIN commented that Alaska is unique and faces different issues than any other state he has worked in or visited. He wanted to talk about what Alaska's vision for health care, discuss the issues of reforming Medicaid versus expanding it and look at the potential benefits of implementing a prevention-based model.

Alaska is extremely rural, which makes implementing programs more difficult thank it would be in the lower 48. It also has issues around access to services, number of providers and its very diverse population. These issues must be overcome through innovative use of people, systems and technology.

3:28:57 PM
The Alaska Department of Health and Social Services (DHSS) in their 2009 priorities included: care management, improved care coordination, a disease-management program for chronic disease and exploring the use of a primary care case-management strategy for the most disabled populations. They also discussed developing legislative and systemic recommendations for reforming Medicaid, aimed at improving Medicaid sustainability. The idea is to get the Medicaid system to the point where it won't continue to chew up more and more of Alaska's scarce budget resources.

As an example, when USPM first began looking at the issues in Florida in 1997, the state was spending about $7 billion on Medicaid; now it is spending $16 billion and it is projected to double by 2015, which means Medicaid spending will represent 50 percent of their budget. Every state is facing a similar issue.

3:29:56 PM
The stated mission of the Alaska Health Care Strategies and Planning Council is "making Alaskans the healthiest people in the nation." Their fifth goal is "prevention and personal responsibility." The Council believes that government has an obligation to jump-start healthy choices through incentives and,

in addition, build the necessary incentive structures for the future.

3:30:21 PM
MR. GOLDSTEIN repeated that the Medicaid system as it is structured today is very fragmented and is designed to take care of people when they are sick, not to prevent illness; it makes no sense to expand a system that is not working well. He recommended that Alaska look at the additional funding that will be coming from the federal government for Medicaid, prevention and health IT as an opportunity to shift the focus within its Medicaid programs in order to affect long-term positive impacts on cost and outcomes for future Medicaid recipients.

3:31:21 PM
To maximize value, Alaska has to change the incentives for all players; appropriate reforms can result in savings to fund expanded eligibility. In addition, there is $1 billion in the stimulus bill for prevention, of which $60 million will be transferred to states to carry out "evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Services Act as determined by the Secretary, that deliver specific, measurable health outcomes that address chronic disease rates."

3:32:34 PM
MR. GOLDSTEIN pointed out some that most beneficiaries don't have the knowledge to manage their own care; they need a physician or other practitioner, an advocate or health coach to help guide them in making good health care decisions.

3:33:34 PM
Health care providers typically don't have the time to provide that kind of advocacy or coaching and they may not have the expertise or the system in place to provide services around behavior change.

Some states have tried to implement pieces of the prevention concept; there have been chronic care management programs in a number of states with more and less success. In the end, it is about changing people's behavior; the state can offer a service, but it will see no results if people don't use it.

3:34:30 PM
MR. GOLDSTEIN stressed that a system must be comprehensive; it should not focus only on chronic disease as Medicaid does, but should begin to focus early on primary and secondary prevention

to help individuals and identify who is at risk and provide those individuals with the resources and services they need to address and minimize those risks. He believes there should be shared accountability among providers, beneficiaries and vendors and that attention should be given to reforming the system of payment to providers, to offer incentives for taking on this new role.

3:35:06 PM
A comprehensive prevention approach should start with a baseline assessment of all beneficiaries; they should know exactly where they stand. Mississippi provided baseline physicals for everyone one year, so the state would know what risks it was facing in that population and could plan for the future. He commented that a state wide shared clinical information system would be really helpful.

MR. GOLDSTEIN asserted that each individual should have his or her own plan and reiterated that the state has to provide comprehensive support, advocacy and coaching for beneficiaries across the continuum so that Medicaid patients, for example, have someone to call who can help them navigate the system and get the services they need.

3:36:00 PM
He said there should be accountability and incentives for both beneficiaries and vendors. In Florida, individuals who do the right things regarding their health earn incentives that go onto a flexible spending account card which they can use to buy over the counter products or services, eyeglasses or additional benefits.

Paying for preventive services is critical and the state should incent positive outcomes; as providers do a good job with patients and practices, they should be incented for that. He added that because of the rural nature of Alaska's population, the state should look to the stimulus package for help with an IT data system.

3:37:33 PM
MR. GOLDSTEIN listed some specific target areas from the FY 2009 DHSS overview:

- Reduce the 30 day re-admission rate for Alaska psychiatric institute to 10 percent from 13.5 percent by putting in a care management program for persons with severe and persistent illness.

- Make sure 80 percent of all two year olds are fully immunized.
- Reduce post-natal death rates to 2.7 per thousand live births by 2010; implementing a high risk care management program for those with maternity issues as one way to reduce the incidents of preterm delivery.

3:38:48 PM
MR. GOLDSTEIN provided examples of successes in the Medicaid program. According to the March of Dimes, preterm births cost an average of $32,000 per child during their first year and Medicaid tends to have a higher percentage of preterm births. In one Medicaid program that enrolled only high-risk mothers, the percentage of preterm deliveries was reduced to 9.4 percent as compared to the national average of 14.8 percent. This program cost $350,000 and the estimated gross savings based on a reduction of preterm deliveries was $900,000 in one year. The estimated savings per baby was $30,000.

The cost of mental illness also falls disproportionately within Medicaid, particularly for those living with severe and persistent mental illness such as schizophrenia or bi-polar disorder. USPM did the first program in the nation for persons with schizophrenia and medical co-morbidities and experienced a 54 percent reduction in per member per month costs for emergency room (ER) visits. As individuals began to get better access to health care and to follow through with the recommendations of their physicians and other practitioners, there was less need for emergency room visits. In that same program, they saw medication adherence rates go from 22.9 days per month to 27.9 days per month in year two for atypical antipsychotics. That change of five days per month is the equivalent of filling two extra months of prescriptions per year.

3:40:54 PM
Representative Lynn joined meeting.

CHAIR KELLER asked Mr. Goldstein to talk about the members of U.S. Preventive Medicine.

MR. GOLDSTEIN said the mental health program he described was implemented in Colorado to manage individuals with severe and persistent mental illness who had schizophrenia with a medical co-morbidity such as diabetes, asthma or heart failure. The goal of the program was to improve the clinical outcomes for those individuals as well as to reduce costs. Individuals were identified through claims data or referred by mental health

practitioners. Nurses on the ground worked with the beneficiaries, their physicians and their mental health providers to ensure that they got appropriate care and followed through with recommendations.

3:42:12 PM
REPRESENTATIVE HERRON asked Mr. Goldstein who are the USPM members.

MR. GOLDSTEIN explained that USPM members are Medicaid beneficiaries who are enrolled in programs that USPM was contracted by the state to provide. He said they sell their programs to employer groups but also work with state Medicaid programs, contracting directly with Medicaid agencies and the state to provide services.

3:42:54 PM
CHAIR KELLER asked Mr. Goldstein to clarify for the record whether USPM is a private company and how it works.

MR. GOLDSTEIN said it is private; they contract with employer groups or with state Medicaid agencies.

3:44:00 PM
MR. GOLDSTEIN continued with slides showing the results of a program done for persons with asthma, coronary artery disease, emphysema, COPD, diabetes, heart failure, sickle cell, depression, schizophrenia, schizoaffective and bi-polar disorders. He explained that the chart represents the overall population within the Medicaid claims data and is an average per member per month of total medical and pharmacy costs; these patients averaged $953 per member per month to the Medicaid program. USPM enrolled only patients who averaged $1191 per member per month and after six months in the program, their average medical costs had dropped over $300 per member per month. Hospital admissions among enrolled patients were reduced by 192 per thousand patients per year and ER visits by 266 per thousand per year.

3:45:30 PM
REPRESENTATIVE SEATON asked Mr. Goldstein to explain how the aggregate eligible population relates to the enrolled patients.

MR. GOLDSTEIN answered that the first column represents the patients they could potentially enroll. The second column is a subset of that, representing the patients who were actually enrolled in the program. The state wanted USPM to do a pilot

with 500 patients; so columns two and three show figures for that subset of the total population.

REPRESENTATIVE SEATON asked if he knows what the aggregate eligible population did during that following year as compared to the target group.

MR. GOLDSTEIN said he believes their numbers were flat; so these reductions were statistically related to the management of the patients.

REPRESENTATIVE SEATON talked through the slide with Mr. Goldstein to be sure he understood.

MR. GOLDSTEIN continued; the next slide shows clinical improvements in a group of very high-cost individuals through the use of in-home telemonitoring devices for blood pressure, weight, respiratory, glucose etc. In that population, the aggregate eligible population per member per month cost was $2000 and they enrolled a subset of people whose per member per month cost was $3200, or $40,000 total per year. The average in-patient cost was $1000 per month for the group and the bed-days were 12,000 per thousand. Again, there was a strong drop in hospital costs to $700 per month.

3:49:50 PM
Monitoring and testing rates among these high-cost individuals also improved substantially in a six month period. For example, foot exams among diabetics went from 12 to 65 percent and A1c testing rates went from 47 to 100 percent. Blood pressure monitoring went from 14 to 32 percent; those on an asthma action plan as recommended by the National Heart Lung and Blood Institute (NHLBI) guidelines went from 26 to 93 percent.

He stressed that it is not an issue of simply reducing costs through fewer services, but of ensuring that individuals get the appropriate services and reduce costs through better management [of medical conditions]. He made it clear that in programs of this nature, one typically sees pharmacy costs go up because patients actually fill their prescriptions and do not skip or miss doses. Savings are created by fewer emergency room and hospital visits.

3:51:16 PM
MR. GOLDSTEIN said that a number of other states are exploring the idea of putting more control in the hands of beneficiaries,

with incentives they can earn by doing the right thing for their health. This is fairly new in the Medicaid arena so he was unable to say yet whether it will have a measurable effect.

MR. GOLDSTEIN commented that small incentives are often very effective when seeking to boost enrollment or to get people to complete clinical assessments. He has seen enrollment rates as high as 80 percent of those eligible within a population. Typically, in the Medicaid populations USPM has worked with, individuals like the program so the number of individuals who leave is very low, generally less than two percent on an annualized basis.

For Alaska's high-cost clients, he recommended that the telemonitoring programs with in-home devices and data managed daily could be very cost-effective even though the products are expensive. Also, E prescribing systems provide better control of prescriptions, reduce inappropriate utilization and improve safety.

3:53:00 PM
Finally, the Alaska Health Care Strategies Planning Council says:

> By improving the place of prevention and personal responsibility in the health and health care decision-making rubric of Alaskans, costs of health care could be lower than they otherwise would be. With concentration on a wellness model of health care, as well as state support for the Community Health Center system and a robust public nursing program, the current access problems could be significantly reduced.

3:53:29 PM
REPRESENTATIVE SEATON wondered if USPM works with providers other than Medicaid and asked if they show the same kind of results.

MR. GOLDSTEIN said yes, they have similar quality and cost-savings results in the commercial market. They have not worked with insurance companies because individuals are afraid to share their data with insurance companies for fear the information they provide may adversely effect their ability to get health care. That is one of the most common concerns they hear from the companies they contract with; those companies want to ensure that USPM is independent and that their data will not be shared

with insurers or employers. U.S. Preventive Medicine is a HIPPA compliant organization and does not share that data. In addition, the average tenure of an insurance company [with an employer] is 28 months; so by remaining independent, they can stay with companies over a longer period of time. They do have contracts with companies that have fully insured products and their program is offered as an add-on.

3:55:37 PM
CHAIR KELLER asked if USPM assists patients when they change providers.

MR. GOLDSTEIN answered that they use a primary nurse model; so each individual has his or her own nurse or health coach who communicates with the individual's providers. The prevention plan itself includes a comprehensive personal record that can be populated by the individual; lab data comes in directly. Individuals can also choose to have their health data transferred into Google Health; so even if a person changes employers, he or she can pay for the plan and keep that data in one place for life.

3:57:07 PM
REPRESENTATIVE SEATON admitted that the legislators' ability to evaluate this is limited. He asked if individual insurance providers like Blue Cross are doing the same kind of thing and if they are seeing the same cost-saving results. He doesn't understand why this wouldn't work through their plans.

MR. GOLDSTEIN said some insurance companies do offer some of these services; typically state insurance regulations require some kind of wellness product or accreditation by the National Committee on Quality Assurance. He believes that the intensity of services offered in USPM's plan is much higher and that is why they have been able to generate better results. Both of Mr. Goldstein's sons have asthma and he said that the disease management program they receive from their insurer is only one phone call per quarter and a mailer.

3:59:59 PM
REPRESENTATIVE COGHILL tried to summarize what he understands from this presentation. The way the insurance system works for getting help to a patient is to work with the doctor, while USPM maintains a closer relationship with the patient for health care management. He asked how their system of health prevention and care management works with the insurance payer delivery system.

MR. GOLDSTEIN said they integrate as closely as possible with insurers, but that is ultimately the individual's decision. Their goal is for individuals to be better able to manage their own care and navigate the health care system. They become the coordinator for individuals' care.

4:02:10 PM
REPRESENTATIVE COGHILL said, what if a patient has high blood pressure, a heart issue and is taking pain medication for a tooth issue; would they know what prescriptions he is taking so they could help him to understand if he is getting a medication that is not of benefit to him.

MR. GOLDSTEIN said yes and, depending on how potentially severe the problem with a prescription, they would even notify the physician. They have found individuals who are getting prescriptions from four or five different physicians, none of whom know what the others are prescribing.

4:03:12 PM
REPRESENTATIVE COGHILL continued; so USPM asks patients to go get specific tests in order to create a database on their health and coach them on their health care decisions.

MR. GOLDSTEIN agreed. They want the patients to have a comprehensive understanding of what their health status is, what their risks look like and what options are available to mitigate those risks. They provide the health coaching, the care coordination, the advocacy and a 24 hour nursing service.

4:04:02 PM
REPRESENTATIVE COGHILL asked how proprietary information is protected. Also, what happens if they make a mistake?

MR. GOLDSTEIN responded that they are URAC (formerly "Utilization Review Accreditation Commission") accredited in their chronic care management and are early adopters of the privacy standards for prevention and wellness programs that the National Committee on Quality Assurance is coming out with now. They are also HIPPA compliant, which means they follow the regulations associated with the sharing of health information; it typically requires authorization from the individual to share their data with anyone else. Because USPM has worked with populations that have illnesses such as HIV/AIDS and mental illness, which have specialized issues around privacy, they have systems built in to maintain privacy for those individuals.

4:05:33 PM
REPRESENTATIVE COGHILL asked if it is at the credentialing of the people doing the coaching where their liability stops. What if a patient misunderstands their advice and then sues?

MR. GOLDSTEIN assured him that they are not providing medical advice. They do have a physician in the system who reviews members' data and provides a physician report; that physician is licensed in the state where the member lives. USPM faces liability as does any other care management organization and has insurance around that process, but they have not had an issue to date.

REPRESENTATIVE COGHILL said the other problem he sees is appointments and no-shows; how do they keep close enough contact with their individual customers so that the program has the most current possible information and is able to give the best coaching.

MR. GOLDSTEIN said the first key is ensuring they have qualified staff. They have been able to recruit great nurses in all of the communities they work in; they have very high standards and provide additional training for all nurses who are hired. They require continuing education for their nurses in every state even though some of the states themselves do not require it for licensing. Then they ensure that they have appropriate staffing levels to meet the needs of the population. For example, if they are working with a population that has schizophrenia, they need a much higher staffing level than they might for a program around wellness or asthma. The nurses develop a care plan for each individual, which lays out how they are going to work together with the individual's physician on their care. In some states that don't have a primary care management model or PCCM, they try to establish a medical home. Finally, they have a very high contact level to allow the nurses to keep up with their individual clients and their physicians. They have seen no-show rates drop on their programs; sometimes nurses go so far as to accompany patients to their appointments. Clearly, they want to get past that high level of "hand-holding" eventually, but that is the level of service they are prepared to provide.

4:09:31 PM
REPRESENTATIVE CISSNA commented on the number of health care positions that can't be filled in rural Alaska; there are workforce shortages even in the urban areas. She asked how their program would work with that; if they would bring nurses into the state.

MR. GOLDSTEIN said that is great question. Typically they do hire within the communities and generally get a lot of applications because it is the type of work nurses like. They get to follow patients for a long period of time; they get to set up their own schedules and really use what they learned in nursing school. Of course, he said, he hasn't applied this to Alaska and can't appropriately answer how that might impact other service providers in the state.

4:11:16 PM
REPRESENTATIVE COGHILL said USPM's brochure talks about four major plans: a prevention plan, custom diagnostics, a wellness plan and an advanced diagnostic plan. He asked Mr. Goldstein to help them understand the cost structure for an individual and how that might be disbursed in a larger plan.

MR. GOLDSTEIN replied that the wellness package, which is the prevention plan itself, includes health risk appraisal, comprehensive lab test series, the physician review and report, the 24/7 nurse line for a year, the coaching and some of the incentives that they throw in, and would cost $1 per day for an individual; companies do receive discounts. They can also un-bundle the program; for example, if a person bought only the internet piece, that would cost about $60 per year. USPM's care management is usually priced for a population based on claims data and can run from a few dollars per member per month up to about $250 per member per month for a telemonitoring system.

MR. GOLDSTEIN commented that most companies [that offer this type of service] charge employers a flat per member per month fee based on the number of employees; so if an employer has 10,000 employees their cost would be the product of that fee times 10,000 employees. A company that charges that way has no incentive to enroll a large number of people because the fewer employees it enrolls, the larger its margin [of profit]. USPM charges only on the number of employees who enroll; so their goal is to get as much participation as possible.

4:14:34 PM
REPRESENTATIVE COGHILL opined that it would be interesting to see what has happened to physicians' and insurance companies' costs and to mortality in areas where their product has come into the market.

MR. GOLDSTEIN said they typically see the cost of primary care visits go up while costs for ER and hospital visits drop. They

haven't looked at insurance overall but have been talking to reinsurers, who are interested in potentially bundling USPM's product with a reinsurance package so they can charge lower rates to providers.

4:15:52 PM
CHAIR KELLER asked Mr. Goldstein to describe the baseline assessment and appraisal and whether they do one for every member.

MR. GOLDSTEIN said they typically want everyone to have an assessment so they can get a feel for what the individual and aggregate risks are within a population. It is a comprehensive health risk appraisal including questions about nutrition, family history and behaviors; that data is combined with lab data. They can either do blood draws on site for employer groups or work with LabCorp, which has 1700 sites across the country where members can go to get lab work done. They have also established relationships with some hospitals and clinics to do blood draws for employers in their communities. When all of the data is in, a risk report is produced which can be accessed by the member online. He noted that USPM is soon coming out with prevention plans specifically for kids at little or no cost and for seniors.

REPRESENTATIVE KELLER asked what the coaching would look like for a member with pre-diabetes.

MR. GOLDSTEIN said that once a report is done, their staff actually contacts the individual to go through the findings and start to develop an action plan. The individual can choose to continue to work with them online or via telephone for ongoing coaching regarding nutrition etc.

4:19:10 PM
REPRESENTATIVE SEATON referred to a chart of per member per month costs that was included in the slide presentation. He assumed that if this reflects a Medicaid result, Medicaid is paying [for the care] and asked who pays USPM.

MR. GOLDSTEIN answered that Medicaid pays them.

REPRESENTATIVE SEATON how this is contracted and why, if these are typical cost savings, federal Medicaid isn't doing this across the country.

MR. GOLDSTEIN explained that typically these [contracts] are released through an RFP [Request for Proposal] and the state selects a vendor they think best fits the RFP requirements. As to why they haven't seen this used more widely, perhaps it is because the programs haven't always worked. For example, there was a huge demonstration project in Medicare involving about 20,000 patients and $25 million. Medicare put out a large bid called "Medicare Health Support" and chose 10 vendors including Humana, Signa, HealthWays, McKesson and others, all of whom attempted to justify their cost savings. These were full risk contracts; if the vendors didn't produce the projected savings, they had to pay Medicare back. None of them worked. He believes the reason the did not work is that they were all very light in terms of behavior modification and were very telephonically based; so it took them a long time to get people engaged and they never did get very high participation rates, which means they couldn't get the results. It was like pushing a five pound brick with four pounds of force; it just wasn't going to happen.

USPM started their business in Medicaid, not in the commercial market and that is a very difficult area; so they have staffed their programs higher than most models and placed emphasis on engaging individuals early. He admitted that they aren't always successful but said they are pretty good at what they do and try every day to get better. About 20 states have signed on so far including: Washington, Oregon, Mississippi, Colorado, Montana, Texas, New Hampshire, New York and Arkansas; some of them have been successful and some have not. The very first program he was involved in was with the state of Florida. There were four vendors doing four different programs; at the end of one year, only their program remained because the other three produced no results.

4:22:34 PM
REPRESENTATIVE SEATON asked if what he is seeing is a sample [of results] and not a whole program.

MR. GOLDSTEIN answered that these are whole program results for one program.

REPRESENTATIVE SEATON said he sees a huge difference between the [numbers for the] aggregate eligible population and the cohort; so there must have been a huge difference in size.

MR. GOLDSTEIN agreed. He said this was a pilot program in seven counties in the Western region of New York. The state asked them

to enroll 500 out of an aggregate eligible population of approximately 3500.

REPRESENTATIVE SEATON continued; so there are 500 in the cohort and the total is 3500 and the data here is from 2007. He asked if the program is ongoing.

MR. GOLDSTEIN said yes, they are doing the last year of data on that program.

REPRESENTATIVE SEATON said, “So this was a pilot project and you have a second year of data?”

MR. GOLDSTEIN answered yes. For this project the state had seven pilots; theirs was the only pilot program continued at the end of 18 months.

REPRESENTATIVE SEATON queried whether the pilot ran through June 30, 2008.

MR. GOLDSTEIN said it is still going on and they will have the last year of data available soon.

4:25:00 PM
REPRESENTATIVE SEATON said he looks forward to seeing an update on that.

REPRESENTATIVE HERRON asked if Mr. Goldstein would agree that the largest patient America has is Medicaid.

MR. GOLDSTEIN responded that Medicare may be bigger; but combined they are about $700 billion.

REPRESENTATIVE HERRON commented that is the next challenge society is going to have to deal with. He wondered what Mr. Goldstein means when he says that Alaska is unique; all states are unique.

MR. GOLDSTEIN said the model they typically use is one that has nurses on the ground work personally with clients; they use this model in North Dakota where each nurse has a geographical region and works with the physicians and patients in that region. They try to bring in culturally appropriate staff to work with the situation. Here, more even than in North Dakota, there are areas that are inaccessible in the winter time and he admitted that he doesn’t know yet how best to handle the big issues Alaska faces

around people who are located in places that have very limited access to services.

4:28:15 PM
REPRESENTATIVE HERRON said he is concerned about returning veterans and the way the [health care] process works; it doesn't even matter which process, whether it is the VA, urban providers or rural providers. Why is it, he asked, that the dollar does not follow the soldier? Why does the soldier always have to fight to find medical services?

MR. GOLDSTEIN said he did not have enough information to adequately answer that question. He thinks the fragmentation of the system is further increased for people returning from overseas. In the chronic care management world, USPM would not exist if every patient and every physician did the right thing and followed through. They are trying to fix the gaps in care in coordination and communication between providers and to help the individual with the least knowledge to navigate the system.

REPRESENTATIVE HERRON said he is almost sold if their company can help the state deal with Medicaid, which he thinks is an almost impossible task. But, he said, if they can make the dollar follow the veterans instead of the other way around, he will be completely sold.

MR. GOLDSTEIN said they are doing a program in North Dakota called "Money Follows People" and are coordinating 100 people through the system so they can get access to the services they need. That may be a way to help the veterans.

4:30:59 PM
REPRESENTATIVE COGHILL said one of the things that is unique about Alaska is that we have a relatively small population in a very large geographical area, which results in big gaps in service delivery. He asked if USPM can achieve economies of scale sufficient to deliver the expected services?

MR. GOLDSTEIN answered that he doesn't think it will be an issue here; there is certainly a large enough population to do it. As an example, one of the organizations that purchased the prevention plan is the Amateur Golf Association of Georgia, which has only nine employees.

4:32:30 PM

CHAIR KELLER commented for the record that a lot of people in Alaska are looking for solutions. He thanked Mr. Goldstein for providing what he believes is encouraging information.

MR. GOLDSTEIN said in closing that there was a health care crisis before there was a financial crisis and it will still be here after the financial crisis is over. He believes that this country has to move into a preventive model or health care costs will continue to increase and will ultimately make the U.S. non-competitive in the global economy. He used the auto industry as an example, saying that the single largest cost of a car for American auto manufacturers is health care. To fix the health care problem we have to get out in front of the train instead of dealing with it after it has left the station.

4:33:57 PM
CHAIR KELLER said they will have a presentation from the Department of Health and Social Services (DHSS) Thursday on Medicaid reform and he believes this was an appropriate lead-in to that.

4:34:17 PM
There being no further business to come before the committee, Chair Keller adjourned the meeting at 4:34 PM.