HOUSE FINANCE COMMITTEE
April 6, 2010
9:09 a.m.

9:09:12 AM

CALL TO ORDER

Co-Chair Stoltze called the House Finance Committee meeting to order at 9:09 a.m.

MEMBERS PRESENT

Representative Mike Hawker, Co-Chair
Representative Bill Stoltze, Co-Chair
Representative Bill Thomas Jr., Vice-Chair
Representative Allan Austerman
Representative Mike Doogan
Representative Neal Foster
Representative Les Gara
Representative Reggie Joule
Representative Mike Kelly
Representative Woodie Salmon

MEMBERS ABSENT

Representative Anna Fairclough

ALSO PRESENT

Representative Bob Herron, Sponsor; Senator John Coghill, Sponsor; Ward Hurlburt, Chief Medical Officer/Director, Division of Public Health, Department of Health and Social Services; Mark Johnson, Member, Alaska Trauma System Review Committee, Juneau; Katie Koester, Staff, Representative Paul Seaton, Sponsor; Eddy Jeans, Director, School Finances and Facilities, Department of Education and Early Development.

PRESENT VIA TELECONFERENCE

Regina Chennault, General Surgeon, Alaska Native Medical Center and Member, Violent Crimes Compensation Board; Frank Sacco, Trauma Director, Alaska Native Medical Center, Anchorage.

SUMMARY

HB 168 TRAUMA CARE CENTERS/FUND

HB 168 was HEARD and HELD in Committee for further consideration.

HB 413 YOUTH ACADEMY FUNDING/REPORT

HB 413 was HEARD and HELD in Committee for further consideration.

#hb168
HOUSE BILL NO. 168

"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

9:09:38 AM

REPRESENTATIVE BOB HERRON, SPONSOR, explained that the legislation would set up a trauma care fund that could reimburse trauma centers for uncompensated or undercompensated services and create incentives for forming trauma centers. The measure could help Alaska establish have more trauma centers and balance services to people in need.

Vice-Chair Thomas MOVED to ADOPT Work Draft CSHB 168(FIN) (26-LS0437\P, Mischel, 3/24/10, copy on file) as a working document before the committee. Co-Chair Stoltze OBJECTED.

SENATOR JOHN COGHILL, SPONSOR, explained that the CS would remove the alcohol tax as a funding source. The CS would establish compensation standards to encourage hospitals to incentivize doctors. Section 1 would remain the same. Section 2 discusses how to manage the funding sources.

9:13:40 AM

Vice-Chair Thomas asked whether the Alaska Native Medical Center (ANMC) was the only trauma center in Anchorage. Senator Coghill replied there were 24 hospitals in Alaska, one Level II hospital (ANMC in Anchorage) and four Level IV

trauma centers. The Alaska Native Medical Center is the only major qualified trauma center in Anchorage; generally, it did not serve the wider population. He pointed out that there were two hospitals in Anchorage (Regional and Providence Hospitals) and one in Fairbanks (Fairbanks Memorial Hospital) that could reach higher levels; the fund was intended to incentivize that process.

Senator Coghill reported that Providence Hospital wanted to be certified under national standards. The doctors at ANMC are on contract and work under the conditions required of Level II centers (doctors have to be on call and able to arrive within 15 minutes or present at the facility). Doctors at Providence and Regional Hospitals work with hospital privileges and are on a rotational call, but there is no guarantee that doctors will arrive at the hospital at a certain time. The protocols and the equipment are different as well.

Senator Coghill stated that the legislation would incentivize for uncompensated and undercompensated care. The fund would incentivize organizations to organize and make agreements about handling emergency responses at the trauma center. He referred to backup materials ("Trauma Care in Alaska 2010" copy on file) and pointed to the American College of Surgeons report (November 2008), which informs the bill. He noted the advantages and assets of trauma care referenced in the report:

- Committed individuals who use their time and expertise every day to serve Alaska citizens.
- Extensive networks for transport.
- 3 large medical centers with extensive subspecialty expertise within the state.
- Large Level I trauma center in Seattle which freely accepts adult and pediatric trauma patients.
- One center maintains ACS Level II verification standards and others have obtained consultations and are working toward verification.
- Alaska Trauma Registry - all 24 acute care hospitals provide data.
- Injury prevention activities are well established.
- Initial efforts at legislative change.

Senator Coghill listed challenges and vulnerabilities:

- No trauma system plan.
- Geography/Weather/Remote and isolated communities.
- No standards or scene trauma triage or trauma inter-facility transfers.
- Trauma system issues have limited visibility within state government.
- Public not aware of trauma system issues.
- Limited human resources.
- Few incentives for hospitals to participate.
- No statewide evaluation of system performance.

9:18:29 AM

Senator Coghill noted that the legislation intended to address the item on the list of challenges regarding few incentives. He added that the College of Surgeons report recommended that the bill mandate [that hospitals achieve trauma care system standards] as some states do. He thought having a fund with incentives was a better approach. The CS included the requirements for getting into the fund and incentives for using it properly. He commended ANMC and urged the rest of Alaskan facilities to follow suit.

Vice-Chair Thomas asked whether the bill would allow non-Native people to use ANMC for trauma situations. Senator Coghill responded that the bill does not address the issue, but there are protocols at the medical center to allow trauma cases. He thought hospitals outside the Native care system needed to step up.

Representative Austerman asked how many hospitals have the ability to take advantage of the fund. Senator Coghill replied that every hospital had the ability. Some hospitals have already gone through the process and gotten a Level IV designation. Of the 24 hospitals in the Alaska, only five have actual designations and nine are under review, leaving quite a few hospitals that could take advantage of the measure.

9:22:42 AM

Representative Austerman asked what steps have to be taken to achieve appropriate status and queried financial barriers. Senator Coghill answered that there are requirements. There are national standard for Levels I, II, III, and IV with different requirements and various

reviews, including staff, equipment, and timeliness of response. He stated that the fund was meant to encourage hospitals to begin the process and to work with the doctors.

Representative Austerman wanted to discern the practical and financial steps necessary to meet the requirements, especially outside major population centers that are able to support expensive equipment. Senator Coghill responded that in most outlying areas, personnel such as Village Public Safety Officers, Emergency Medical Services (EMS) personnel, public health officials, and medical transport personnel would work to stabilize patients in order to get them to the next level of care needed. A hospital will perform at the level it can. The fund would provide incentives to get hospitals to the highest level possible. The reality is that there will not be a Level I hospital in Alaska, as a facility at that level must be a teaching hospital. Alaska can have level II facilities, like the ANMC. He thought Fairbanks could rise to a Level III, which would enable them to stabilize and prepare patients for treatment.

9:26:37 AM

Representative Austerman queried the cost factors of the fund. Senator Coghill responded that they had looked at the trauma mandates and requirements throughout the U.S. and calculated for Alaska's population base and geography. The sponsors thought that having $5 million in a fund would adequately provide the ability to give incentives. The money could be divided several ways. Some of the Medicaid money could be matched by state money. Hospitals get a certain amount for Medicaid that they are able to use for match money. Services with billing must be performed in order to access the money. He thought there were other ways to enhance Alaskan dollars. Research on funding sources resulted in a preliminary list, including funding private sources and grants, but he believed the state should put some money in to get the fund in place.

Representative Austerman pointed to page 2, line 11, regarding spending up to 25 percent of the fund for one facility and queried how to replenish the fund. Senator Coghill responded that he did not want any one hospital to dominate the fund. He thought it would be unwise to deplete

the fund. He was open to discussion; the provision was just a way to limit one entity from getting all the assets.

9:30:35 AM

Representative Austerman commented that up-front money would be needed to get started, plus there would be annual needs. He was not optimistic about pulling funds from the sources referenced on the list.

Representative Foster queried the total need relative to the $5 million. Senator Coghill responded that the number was a judgment call. He reported that other states have mandated meeting the standards and put the cost on the facilities. He thought that factors unique to Alaska would affect the situation. He viewed the fund as a way for the state to contribute to the process. He agreed that the total need was unknown. He pointed out that the hospital association and the insurance people would have numbers.

Representative Foster referenced a fact sheet from the Alaska Statewide Trauma Center saying that in 2004, the economic cost of hospital stays alone for trauma patients in Alaska was estimated at over $73 million; one in four hospital admissions were uncompensated. He asked whether there were updated numbers. Senator Coghill replied that much of the uncompensated care would be picked up by the state or Medicaid, requiring matching funds. He recommended taking Medicaid (disproportionate share) money and matching it to get more money. He thought the window in which to do that from the federal government might be two or three years.

Senator Coghill argued that people would not get served and would die if the state did not incentivize trauma care. The state was already spending money for trauma care.

9:34:35 AM

Vice-Chair Thomas queried using alcohol and tobacco tax as other states do. Representative Herron responded that the House Health, Education and Social Services Committee had discussed the major causes of the kinds of trauma cases coming to hospitals and determined that alcohol was related. There was discussion as to why the alcohol money would not work.

Senator Coghill explained that both the tobacco and alcohol taxes were considered, but they are general funds. The proposed fund would have the option of drawing other money as well. Some states use vehicle registration funds, as the vast majority of trauma cases result from using alcohol and vehicles together. He emphasized that there are other ways to collect the funds, including increasing alcohol taxes.

Vice-Chair Thomas referred to previous legislation related to tobacco tax and questioned why the tobacco tax could not be used.

9:38:15 AM

REGINA CHENNAULT, GENERAL SURGEON, ALASKA NATIVE MEDICAL CENTER and MEMBER, VIOLENT CRIMES COMPENSATION BOARD (via teleconference), spoke in support of the legislation. She informed the committee that she also served on the Alaska Trauma System Review Committee and was the American College of Surgeon's chair for Alaska's Committee on Trauma. She pointed out that trauma was a public safety threat for all citizens. She had seen people die because of the lack of standards. She emphasized that the state is paying through Medicaid dollars for some of the care, but the quality of care that the rest of the nation receives was not being met.

Representative Joule asked for elaboration regarding the level of care in Alaska. Dr. Chennault described a recent experience in an Anchorage hospital related to a violent act. She had received a complaint because a person had been picked up with life-threatening injuries; the emergency personnel had tried to take her to one hospital (she would not name the hospital) but the patient was turned back because no surgeon was available. The patient was brought to ANMC with good results, but she could have easily bled to death without timely care. She was aware of other similar cases during her tenure in Alaska.

Representative Joule asked how the legislation would change the situation. Dr. Chennault referred to the review done by the College of Surgeons (copy on file) listing 70 major problems with Alaska's response system. She described care that was automatically given in other parts of the country. The important issue is timely care. Some hospitals do not want to put up the money to train doctors and nurses. She added that in the private sectors, doctors do not want to

be required to arrive at a hospital within 15 minutes, which could mean the difference between life and death for a trauma patient.

Representative Joule asked whether the goal of the legislation was to change the behavior of service providers. Dr. Chennault replied yes, to change the behavior of both providers and hospitals, because sometimes it comes down to training, equipment, or response protocols. She pointed out that the same capabilities were the backbone of preparedness response for natural disasters like earthquakes.

9:43:21 AM

FRANK SACCO, TRAUMA DIRECTOR, ALASKA NATIVE MEDICAL CENTER, ANCHORAGE (via teleconference), testified in support of the legislation. He noted that the issue was a public safety issue that applied to everyone, because a trauma system decreases mortality by 15 to 25 percent.

Dr. Sacco informed the committee that he had been chair of the Trauma System Review Committee and was the Trauma Director at ANMC. He has been involved in developing a trauma system in Alaska for 15 years. The original legislation set up the framework for a trauma system but did not provide incentives or disincentives for hospitals to participate, and little progress was made. He pointed to recommendations by the College of Surgeons' review.

Dr. Sacco explained that ANMC takes seriously injured patients and would never turn a patient away. However, ANMC has limited capacity and is often 100 percent full. It has served as a safety net for the broader community, but at times has been the only hospital available to take care of critically injured children for several months at a time. He wanted all the hospitals to be at Level II response capability; the fund in HB 168 would allow hospitals to help doctors be available on short notice. The costs to smaller hospitals without surgeons would not be very large, which is why there are four hospitals in rural areas at Level IV capability, including Norton Sound Regional Hospital (Nome), Yukon-Kuskokwim Delta Regional Hospital (Bethel), Sitka Community Hospital (the only private hospital), and Mt. Edgecumbe Hospital (Sitka).

Dr. Sacco emphasized that the most important part of the system was continuous re-evaluation of care and outside review of care, which results in steady improvement. He believed HB 168 was a good start and that the incentives were important. He thought if the incentives did not work, then more would be needed. He pointed out that the size of the $5 million fund amount was taken from states with similar population.

9:48:20 AM

Representative Joule referred to the fact sheet stating that more than 400 Alaskans die from trauma each year and that more than 800 Alaskans are hospitalized because of trauma. He asked whether the numbers would have been lower if there had been trauma centers in place. Dr. Sacco responded that other states have been able to decrease the mortality rate related to trauma by 15 to 25 percent. He believed that saving even 10 percent of the lives of trauma victims, or one person each week, would have tremendous impact. He reminded the committee that for every patient that dies, three people are left with permanent disabilities. Those people will never work at the level they once had worked and the state would have to provide additional resources. He underlined that the legislation would save lives and emphasized that Alaska has the second highest death rate from trauma in the country.

WARD HURLBURT, CHIEF MEDICAL OFFICER/DIRECTOR, DIVISION OF PUBLIC HEALTH, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, spoke in support of the bill. He remarked that his clinical background was as a general surgeon, and that he had worked many years in Alaska's Native healthcare system. He was very involved with trauma systems and had served as Director of ANMC. He emphasized that the administration supported the concept of HB 168 and was neutral regarding the fiscal note.

Dr. Hurlburt informed the committee that the U.S. had adopted the kind of system that has been described as the way to deal with trauma. He noted that studies conducted nationally and reported in the New England Journal of Medicine have documented that trauma victims who receive care in certified and designated facilities have a better survival rate.

Dr. Hurlburt described the process of setting up a trauma system. The American College of Surgeons Committee on Trauma comes to a hospital, uses criteria to develop a report, and certifies whether a hospital meets the criteria. The state then designates the hospital as far as levels. He did not believe there would be a Level I trauma center in Alaska; Harborview Hospital serves as the Level I trauma center for Alaska, Washington, and Idaho, and much of Montana. However, ANMC is a Level II trauma center that meets the necessary criteria; it does care for non-Native people, but does not have the capacity to take care of the other 85 percent of the population of Alaska on a regular basis. As a result, Alaska is the only state where most of the population does not have access to a Level I or II trauma facility. Anchorage is the largest city in the U.S. without a Level II trauma center. He declared that Alaska is not participating in a system documented to save lives.

Dr. Hurlburt stated that the department would like to see every hospital reach its appropriate designation. He noted Sitka Community Hospital, a small hospital that took the issue seriously and was able to meet the criteria. He thought Level III would make the most sense for Fairbanks Memorial Hospital. To achieve Level II, surgeons must be available within 15 minutes. The surgeons at ANMC generally stay in the hospital at night when they are on call; part of the reason is that the facility has become increasingly busy. The 15-minute availability is a major issue in other Anchorage hospitals.

Dr. Hurlburt reported talking with the administrator of the hospital in Soldotna, which would look at a Level III. Ketchikan had recently looked at becoming a Level III hospital, but did not meet the criteria because of equipment.

9:56:28 AM

Representative Austerman asked whether the amount available in the $5 million fund could get Anchorage hospitals to a Level II designation. Dr. Hurlburt replied that as a surgeon, he had expected to be on call. Younger doctors expect to be paid more to be on call. The Alaska Health Commission (which he chairs) calculates that approximately $6 billion is spent in Alaska per year on health care, a huge part of the state's economy. Physicians expect to be compensated. He estimated that the $5 million was a good

amount, although only time would tell if it was enough. He provided the example of two hospitals in Tacoma and Pierce County in the state of Washington that had developed joint compensation for an on-call system. Other states have simply mandated that hospitals meet the standards.

Representative Joule noted that ANMC was designated as a Level II facility, but that its certification had been due in 2009. He asked whether the facility had been recertified. Dr. Hurlburt responded that they were recertified and have maintained the three-year certification.

10:00:31 AM

MARK JOHNSON, MEMBER, ALASKA TRAUMA SYSTEM REVIEW COMMITTEE, JUNEAU, spoke in support of the measure. He described his experience as the chief of emergency medical services for the state. He had been involved in the 1993 legislation and the subsequent development of regulations. The American College of Surgeons standards had been adopted; the same standards were part of HB 168. He had taken part in reviews of eight hospitals in Alaska. They had had a federal grant but it expired and momentum was lost. Many studies have been done showing the difference in outcome when standards are being met. He noted that trauma was the number one cause of death for ages 1 to 44 and a major cause of death and disability for all ages.

Mr. Johnson believed that HB 168 would move the state in the direction of getting hospitals to meet national trauma system standards. He described the process used in Alaska and noted lesser expense for small rural hospitals. He pointed out that the American College of Surgeons had 16 major recommendations. He commended work done to implement some of the recommendations.

Mr. Johnson stated that undocumented care has cost $20 million; he was hopeful the $5 million fund was enough to move forward.

Mr. Johnson emphasized that a certain percentage of people who get definitive care within the first six to ten hours would result in a better outcome and that the rural hospitals could make the difference. He thought there could be more prevention as well.

10:06:07 AM

Representative Austerman referenced the six-to-eight-hour time period and asked about level designations. Mr. Johnson answered that Level IV is the most basic level identified. He pointed out that rural health clinics in Alaska have to be considered. They would not be covered by the bill, but their personnel also need the right kind of training.

Representative Austerman queried the number of hospitals in the state with the potential to get to Level IV. Mr. Johnson replied that every hospital in the state besides Fairbanks, Mat-Su, Anchorage, Kenai Peninsula, Juneau, or Ketchikan could be at Level IV. He listed hospitals that could be various other levels. He emphasized that it could be done.

Co-Chair Stoltze closed public testimony.

HB 168 was HEARD and HELD in Committee for further consideration.

#hb413
HOUSE BILL NO. 413

"An Act relating to the Alaska Challenge Youth Academy."

10:10:02 AM

KATIE KOESTER, STAFF, REPRESENTATIVE PAUL SEATON, SPONSOR, explained that the bill would restructure the funding formula for the Alaska Challenge Youth Academy [also called the Alaska Military Youth Academy (AMYA)], a highly successful residential program for high-school drop-outs. Based on a national challenge model, the academy serves an important population that struggles in regular school. The academy has a 70 percent graduation rate; graduates receive a GED or diploma over an intensive 22-week course. The students are then followed for another year and are considered a success if at the end of the year they are in college or the military, attending vocational education school, or employed at least 30 hours per week; the success rate for the program is 93 percent.

Ms. Koester explained that the education committee had been tasked with finding a more realistic formula for funding

the academy. The current funding formula for AMYA is 7 times the base student allocation (BSA) for residential students, 0.6 times the BSA for non-residential students, less any federal funds received. For the current year, the numbers were 7 times $5,680, 0.6 times $5,680, minus $2.7 million in federal funding, or $5.8 million in general fund dollars. The committee was concerned that the increases in the BSA do not necessarily correlate with the increased costs at the academy. She explained that HB 413 would address the formula problem by taking a number ($11,990) and setting it in statute and multiplying that by the number of residential and non-residential students. The result would be approximately the same figure, $5.8 million. The number would be set in statute, and the academy would need to come to the legislature when they needed more funding.

10:13:18 AM

Co-Chair Stoltze asked for more information. Ms. Koester replied that Mt. Edgecumbe is funded through the BSA for the instructional component and funded under the Department of Education and Early Development (DEED) budget for the residential component. She noted that the population served by the academy requires 100 percent supervision and is more high-needs than the Mt. Edgecumbe population, which is more high-achieving.

Representative Gara asked whether the number was currently tied to the BSA. Ms. Koester answered yes.

Representative Gara asked whether implementing the change would cause a lag in funding, since the BSA tends to increase each year. Ms. Koester responded that the legislature has shown commitment to the program and the academy would be able to get increases when needed. She acknowledged concerns that had been expressed that it may not increase at the same rate as 7 times the BSA. When Public Employee Retirement System (PERS) and Teachers Retirement System (TRS) costs were rolled into the BSA, the academy received larger funding.

Ms. Koester noted that the Department of Military and Veterans Affairs (DMVA) was in favor of the legislation.

Co-Chair Hawker stated strong support for the "innovative and successful" program. He noted discussion of the issue

three years prior in the joint legislative educational task force; the issue of the correlation between the BSA and the needs of the academy was discussed and deferred to the education committee.

Co-Chair Hawker stated concerns about putting a set number into statute when the number was inherently not durable. He pointed out an alternative to the formulaic programs fixed at 7 times the BSA was to disconnect the academy from a formula and have it come back each year and get into the operating budget based on actual annual needs.

Co-Chair Hawker believed the fixed number was inflated, resulting in the mentioned windfall. He reiterated concerns.

10:18:47 AM

Co-Chair Hawker questioned the number chosen and whether it accomplished the greatest good.

Representative Austerman echoed support for the program for young people with problems. He asked whether there would be federal funds for the program in the future. Ms. Koester replied that there would still be federal funds.

Representative Austerman thought the numbers would represent a substantial increase based on a flat figure plus the federal funds. Ms. Koester clarified how the figure was arrived at and explained that the general fund number would be the same.

EDDY JEANS, DIRECTOR, SCHOOL FINANCES AND FACILITIES, DEPARTMENT OF EDUCATION AND EARLY DEVELOPMENT, explained that the department was supportive of the academy program and was simply a conduit for the program's revenue. His direction working with the education committee was to keep the state general funds at the same level as the FY 11 budget. He mentioned a $600,000 state general funds reduction in the department's FY 11 budget request because of a federal fund increase anticipated by the academy.

Co-Chair Hawker reiterated concerns regarding the number. The federal funding fluctuates.

10:23:38 AM

Representative Gara suggested pegging the annual student allocation to a multiple of the BSA. Ms. Koester responded that pegging the number to the BSA has not worked in the past because of the volatility of the number and because the needs addressed are different. The education committee wanted to get away from the formula. She noted that the number ($11,990) was the number that DMVA said they needed and could work with to deliver the same level of services.

Co-Chair Stoltze hoped to talk to DMVA to check the numbers.

Representative Kelly referred to concerns, including that a different multiplier (five times) had been looked at. He queried how the bill would address the perennial problem of the count at the academy. Mr. Jeans replied that tying the funding to the BSA did not work because of the increased TRS costs, which raised the BSA; the employees at the academy are PERS employees. The PERS increase was not as large, resulting in an unintended windfall to the youth academy. He stated that DEED was comfortable with moving away from tying to the BSA. He believed DMVA was also comfortable with the approach. In terms of the count, he had considered the number of students served through the program, both residential and non-residential and found that the number does not change much over multiple years. He had not looked at using multiple counts. He pointed out that annual operating costs would still be needed.

HB 413 was HEARD and HELD in Committee for further consideration.

10:28:23 AM

#
ADJOURNMENT

The meeting was adjourned at 10:28 AM.