

HOUSE FINANCE COMMITTEE  
February 13, 2012  
9:06 a.m.

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CALL TO ORDER

Co-Chair Thomas called the House Finance Committee meeting to order at 9:06 a.m.

MEMBERS PRESENT

Representative Bill Stoltze, Co-Chair  
Representative Bill Thomas Jr., Co-Chair  
Representative Bryce Edgmon  
Representative David Guttenberg  
Representative Tammie Wilson

MEMBERS ABSENT

Representative Anna Fairclough, Vice-Chair  
Representative Mia Costello  
Representative Mike Doogan  
Representative Les Gara  
Representative Reggie Joule  
Representative Mark Neuman

ALSO PRESENT

Representative Wes Keller; William Streur, Commissioner, Department of Health and Social Services; Kimberli Poppe-Smart, Deputy Commissioner For Medicaid And Health Care Policy, Department Of Health And Social Services.

SUMMARY

PRESENTATION:

MEDICAID 101 & THE AFFORDABLE CARE ACT & ITS IMPACTS  
ON ALASKA

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^PRESENTATION: MEDICAID 101 & THE AFFORDABLE CARE ACT & ITS  
IMPACTS ON ALASKA

WILLIAM STREUR, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced staff and provided members with a PowerPoint presentation: Partnerships, Medicaid Review 2012 (copy on file).

KIMBERLI POPPE-SMART, DEPUTY COMMISSIONER FOR MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, observed that Medicaid was started in 1965 and utilized state and federal funds. The program was managed by states to provide care to low-income individuals; two-thirds of the program coverage went to children and the elderly. She shared that each state in the nation ran the program differently; for example, some states had childless adults in their coverage group. Medicaid provided health insurance to approximately 60 million Americans and was 18 percent of the \$3 trillion spent by the federal government on healthcare. She said that the state's \$1.5 billion budget paid for the 92 percent of the nearly 146,000 Alaskans that were eligible for the program.

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Co-Chair Stoltze asked if the 146,000 represented single applicants, or a whole line of dependents.

Ms. Poppe-Smart replied that 146,000 was the number of eligible individuals.

Ms. Poppe-Smart continued. The program supported providers and served as a safety net for individuals who would not otherwise have healthcare coverage. Additionally, Medicaid was the primary payer for long-term care services and behavioral health services. She said that access through Medicaid was comparable in many states to private health insurance. In Alaska, healthcare expenditures in FY10 were approximately \$7.5 billion, Medicaid represented 18 percent of those expenditures, as well as 32,000 jobs.

Ms. Poppe-Smart turned to Slide 4 titled, "National Percentage Change in Total Medicaid Spending and Enrollment FY 1998 - FY 2011," which reflected the rise and fall over economic times in relation to Medicaid enrollment.

Ms. Poppe-Smart highlighted Slide 5 titled, "Percent Change in Alaska's Total Medicaid Spending and Enrollment: FY 1998 - FY 2011." She stated that work had been done across the states in order to eliminate, or reduce, barriers to enrollment. She mentioned "express lane eligibility," which

was a national program that gave children that were eligible for school lunch programs presumptive eligibility for Medicaid. She furthered that the intention of the express lane eligibility was to identify individuals, primarily children, of low economic status that would not otherwise be eligible for Medicaid.

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Representative Edgmon asked if the 32,000 jobs created by Medicaid were in-state.

Ms. Poppe-Smart said yes.

Representative Edgmon asked if the growth in healthcare jobs in the state could be attributed to Medicaid.

Ms. Poppe-Smart replied that the state represented 18 percent of Medicaid's expenditures, which could correlate to the increase of jobs overtime that could be funded because of Medicaid contributions.

Representative Edgmon thought that it would be interesting to see the number of Alaskan jobs that were tied to Medicaid.

Ms. Poppe-Smart said she would work to provide the information to the committee.

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Ms. Poppe-Smart stated that Alaska's economic ebb and flow paralleled the national economy, with a slight delay in actual impacts. She said that Alaska's increasing elderly population would cause rolls and expenditures to increase over time. Nationally, dual eligibles accounted for 40 percent; the numbers were lower in the state, but it was anticipated that they would increase.

Co-Chair Stoltze asked if the department was presenting Medicaid as an economic engine.

Ms. Poppe-Smart replied in the affirmative.

Representative Wilson wondered how many Medicare recipients in the state were also benefiting from Medicaid.

Ms. Poppe-Smart replied that there were 14,500 dual eligibles in Alaska; individuals that became Medicare eligible because of age were also eligible for Medicaid.

Representative Wilson asked how many people were dual enrolled because their Social Security payments were not enough to cover healthcare.

Ms. Poppe-Smart replied that there were a number of individuals that became eligible because of health status.

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Ms. Poppe-Smart reviewed Slide 6, which was a map of the Statutory Federal Medical Assistance Percentages (FMAP) FY 2012. She said that Alaska was at a 50 percent match rate for general Medicaid. She stated that the last of the American Recovery and Reinvestment Act (ARRA) dollars had been distributed in June 2011. Those funds had translated to an enhancement in the state's FMAP rate. She clarified that if there was a Tribal Health beneficiary that was receiving services from a Tribal Health provider the reimbursement rate for the service itself was 100 percent. She added that there were breast and cervical cancer, as well as children health insurance programs that had enhanced FMAP rates. She relayed that the formula that the FMAP rates was based on considered unemployment rates, general economy and number of participants. She furthered that nationally, with the loss of the enhanced ARRA funding federal match rates sank 10.8 percent; Alaska experienced the decrease at 4 percent. She reported that Medicaid had been growing at a slower rate per enrollee than national health expenditures per capita and private health insurance companies.

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Co-Chair Stoltze asked how much of the slower growth rate could be attributed to the lower rate paid to Medicaid.

Ms. Poppe-Smart replied that in Alaska the rates were comparable to private health insurance. She said that across the nation the reimbursement for Medicaid was below other payers, in some cases even below Medicare rates. She thought it was possible that there was a lower participation rate by providers, but she could not

speculate as to how much the smaller growth per enrollee played a part.

Representative Wilson expressed disbelief that Medicaid payments were comparable to private insurance.

Ms. Poppe-Smart assured the committee that comparisons would be done during the presentation. She clarified that Medicaid paid less than commercial insurance in Alaska, not necessarily nationwide.

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Ms. Poppe-Smart discussed Slide 8 titled, "Controlling Growth in Medicaid." She explained that there were four ways to control growth in Medicaid growth:

- Eligibility
- Covered Services
- Rates
- Utilization Controls

Ms. Poppe-Smart stated that the list on the right hand side of the slide highlighted other efforts being made to control Medicaid spending:

- Compliance/Anti-Fraud
- Innovations in Service Delivery
- Technology
- Maximize Revenue

Ms. Poppe-Smart spoke to Slide 9, which involved a bar-type chart detailing what different states were doing in response to the economic climate. She said some states were increasing payments, some were decreasing, some were increasing and decreasing; some states had found that dentists needed to be reimbursed at a higher rate to get adequate dental coverage for recipients. She relayed that some states were cutting provider rates in an attempt to control the growth in Medicaid programs and subsequently their state budget deficits. She said that eligibility had increased nationwide and that some state-only funded programs had appeared. She said that the home and community bases service program in Alaska was strong, with less institutional care provided. Alaska had approximately 708 nursing home beds.

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Ms. Poppe-Smart discussed controlling costs through eligibility. She explained that when the state received enhanced funding under ARRA, the maintenance of effort requirement was imposed on the states. Under the requirement the state could not eliminate or reduce eligibility categories.

Co-Chair Stoltze asked if the long-term maintenance of effort restrictions were a result of the short-term ARRA funding.

Ms. Poppe-Smart replied yes, the restrictions were extended through the Affordable Care Act through 2014. She said that the maintenance of effort restrictions still applied to the state, but with some possible exceptions.

Ms. Poppe-Smart discussed covered services. She said that mandatory services generally included nursing homes, hospitals and out-patient providers. She relayed that optional benefits usually included home and community based programs and pharmacy services. She said that elimination of optional services would lead to more demand in mandatory services. She referred to the scenario as the "shifting bulge," and asserted that most optional services were not really optional when looking at the big picture. She said that examples of cuts due to budget deficits could be found across the country.

Ms. Poppe-Smart stated that the Centers for Medicare and Medicaid Services (CMS) would not approve changes to programs that would impact access to necessary services. She said that in May of 2011, CMS put forward a proposed rule that would require the department to study access for each service category for a year to demonstrate that access would not be infringed upon. She stressed the CMS was diligent about vetting any State Plan Amendments (SPA) to make changes in services, including changes to rates, services and eligibility.

Representative Wilson asked if the federal ARRA funding and The Affordable Care Act (ACA) had caused the restrictions.

Ms. Poppe-Smart replied that the maintenance of effort requirement originated with ARRA funding and was extended through the ACA. She observed that the state did not take

the ARRA funding. She explained that by continuing to participate in the Medicaid program the state must follow the rules.

Representative Wilson asked if the restriction would still exist if Medicaid was state funded.

Ms. Poppe-Smart responded that if the state had elected to decline the \$900 million in federal Medicaid funding, the state could make its own rules but would lose federal matching funds.

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Ms. Poppe-Smart turned to Slide 13, which listed mandatory and optional services:

#### **Mandatory**

- Inpatient hospital
- Outpatient hospital
- Physicians
- Nurse midwives
- Lab and X-ray
- Advanced Nurse Practitioners
- Early Periodic Screening, Diagnosis, and Treatment
- Family planning services
- Pregnancy-related services
- Nursing facility (NF) services
- Home Health (NF qualified)
- Medical/surgical dental services

#### **Optional**

- MH Rehab/Stabilization
- Diagnostic/Screening/Preventive
- Therapies (OP,PT,SLP)
- Inpatient psychiatry<21 years
- Drugs
- Intermediate Care Facility/Mental Retardation
- Personal care
- Dental
- Other home health
- Other licensed Practitioners

- Transportation
- Targeted Case Management

Ms. Poppe-Smart stressed that optional services were not always optional.

Co-Chair Stoltze took offense with the term "mental retardation." He hoped a different term would be used in the presentation into the future.

Ms. Poppe-Smart responded that a national change in terminology to "intellectual disability" was under discussion.

Ms. Poppe-Smart discussed rate control. She relayed that 39 states in the nation were looking to control rates by freezing or reducing them. She observed that reducing rates in one area may cause cost increases in another. She said that some rate reductions had ended in litigation. She noted CMS approval of an SPA was necessary and could impact access and quality of care.

Co-Chair Stoltze emphasized the cost of not being able to charge Medicaid for no-shows. He wondered if the issue had been examined.

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Ms. Poppe-Smart noted that the department looked into no-shows for dental providers. She observed that the no-show rate was not higher among Medicaid users than for commercial providers. She said that the problem existed across the board. She asserted that covering no-shows would put pressure on CMS and would pose the question of the state covering the cost of no-shows.

Representative Wilson pointed out that self-payees were responsible for their no-show costs whereas Medicaid recipients were not.

Ms. Poppe-Smart understood that there was a financial impact for no-show self-payees. She reiterated that the rate of no-shows was not higher for Medicaid recipients than self-pay patients or people covered by private plans.

Co-Chair Stoltze echoed Representative Wilson's concern.

Commissioner Streur acknowledged the issue. He pointed out to the committee that the issue was not just a no-show issue, but that it was a challenge for providers. He said that the state was precluded under federal law from paying for no-shows, unless general funds were used. He assured the committee that solutions were under discussion.

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Co-Chair Stoltze asked if the no-show problem was worse among Medicaid recipients than the rest of the population.

Commissioner Streur explained that a study performed by dental providers showed that the numbers were not higher for Medicaid patients than self-providers. He said that dental providers did take issue with the inability to charge the state for no-show patients covered by Medicaid.

Representative Guttenberg suggested that there could be a division between other medical providers and dental providers. He wondered if the no-show issue could stem from the nature of the service being provided. He stressed that many people had an aversion to dental care.

Ms. Poppe-Smart replied that she did not have any data on no-shows regarding other medical providers.

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Ms. Poppe-Smart looked to Slide 14, which provided payment comparisons from the Milliman Client Report: Physician Payment Rates in Alaska and Comparison States prepared for the Alaska Health Care Commission in 2011. The slide reflected two different categories of service: Office Visit and Obstetrical Care; and the payment methods; Alaska Medicare, Alaska Medicaid, Alaska Commercial Mean, Washington Medicaid, Washington Commercial Mean, North Dakota Medicaid and Idaho Medicaid. She shared that Alaska paid a higher rate than most states for Medicaid and higher than some commercial providers.

Representative Wilson queried the consequence of paying higher Medicaid rates than other states in the country. She expressed concern that people would move to Alaska to benefit from the higher rate Medicaid coverage.

Ms. Poppe-Smart responded that she did not have data to validate that assumption. She acknowledged that some patients came to the state to be cared for by family residing in Alaska.

Representative Wilson believed that there was a correlation between people moving in-state and the higher Medicaid benefits. She suggested that Alaska should lower coverage in order to stay in the same realm as other states.

Co-Chair Stoltze interjected that the correlation would be hard to determine.

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Ms. Poppe-Smart reminded Representative Wilson that the rates were paid to providers and not recipients, which should result in more providers moving to the state and not recipients. She observed that rural areas were addressed differently. She said that the department did not receive complaints that people found it difficult to access services in the program. She stressed that people in other states had complained of the difficulty in finding a doctor that would take their Medicaid rate.

Representative Wilson pointed out the difference between Medicaid and commercial rates. She maintained that Medicaid did not offset the additional cost of paperwork. She said that she thought that the system was "pretty poor."

Ms. Poppe-Smart rebutted that Health Care Commission studies had reflected a higher cost of health care in Alaska in general, but had not yet identified the cause.

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Ms. Poppe-Smart continued to Slide 15, which highlighted utilization controls:

- States may impose utilization controls to ensure appropriateness of treatment being funded
- Wide range of controls and screens
  - Prior Authorization
  - Post payment reviews
  - Hard or soft edits
  - Bundling, unbundling, and order of billing

- o New Edits and audits for FFS (fee-for-service)

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Ms. Poppe-Smart looked to Slide 16, which discussed compliance and anti-fraud:

- In some states may be an untapped area for savings
- Fraud in Medicaid is a reality
- Numerous methods and vendors
- Fraud undermines the entire program
- Politically popular reduction

Ms. Poppe-Smith explained that the federal government was concerned \$22.5 billion in improper payments that were made to Medicaid in FY10. She noted that Alaska had a relatively small provider population.

Representative Guttenberg asked if there was a breakdown available to separate intentional fraud and simple miscoding mistakes.

Ms. Poppe-Smart replied that fraud cases in Alaska were handled by the Medicaid Control Unit under the Department of Law. She said that few cases in the state resulted in prosecution, as compare to the national numbers. She added that fraud had proven a problem in larger urban areas of the country. She shared that there was an active surveillance and utilization system that tracked patterns of practice and payments in the attempt to identify any problems.

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Co-Chair Stoltze questioned if there was a quantifiable fraud percentage.

Ms. Poppe-Smart responded that there was not a quantifiable percentage available. She said that the Division of Public Assistance had a unit dedicated to examining fraud concerns. She explained that the department examined the statutory required audits. She stressed the department had programs already in place to look for, and prevent fraud, and did not believe that it was a rampant problem in Alaska.

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Representative Wes Keller probed the efforts taken by the department to control fraud.

Ms. Poppe-Smart stated that the process began with the enrollment of a provider; inspector general records were examined to determine any history of fraudulent activity or exclusion in other state programs. She furthered that a surveillance and review team looked to claims payment systems for any suspicious patterns. She added that the department sometimes received reports from individuals; explanation of benefit reports helped individuals review their claims. She furthered that the department had a program integrity team that worked with audits. She shared that the error rate in Alaska for 2008-2009 was one of the lowest in the nation. She stated that statutorily mandated audits occurred on a regular basis and any fraudulent activities were referred to the federal government. She noted the existing compliance efforts in Alaska:

- Surveillance Utilization Review (SUR)
- Audits required by AS 47.05.200
- Credit Balance Audits
- Focused reviews
- CMS Medicaid Integrity Program
- Payment Error Rate Measurement
- "Cluster Audits"
- Medicaid Recovery Audit Contractors
- Medicaid Fraud Control Unit (MFCU)
- Provider, referrer, prescriber, renderer enrollment
- Medicaid Recovery Audit Contractor

Co-Chair Stoltze asked if it could be determined were fraud existed.

Ms. Poppe-Smart replied that there was a small number of fraud on both the provider and the recipient end. She stated that she did not have the figures at hand.

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Representative Wilson asked how much the state was paying to handle fraud cases versus how much was recouped from prosecution.

Ms. Poppe-Smart responded that the department would work to would provide data. She believed that due to low the incidences of fraud the department paid more in administrative cost than was recovered.

Representative Keller shared that federal measurements of error rates involved insuring that recipients received the maximum benefits allowed by law.

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Ms. Poppe-Smart continued to Slide 17 which showed where recoveries had been, she noted that the numbers were not an identification of fraud but audits where an overpayment had been made, usually in an instance where there had not been documentation in provider's records to support the payment that was made through the claims system.

Ms. Poppe-Smart turned to Slide 19, which listed innovations in service delivery and payment:

- Medical Home
- Tribal Health - exemplar of alternative provider types
- Bundled services
- Integrated Bills previously Heard or Scheduled./Primary care services
- More

Ms. Poppe-Smart said that medical homes worked because they provided case managers that helped patients manage chronic medical conditions and stay on top of care needs; additionally, it had lowered the rate of emergency room visits for those patients. She shared that some of the medical home programs that had started across the country had witnessed a 10 percent savings in Medicaid costs.

Co-Chair Stoltze spoke to the Tribal Health Consortium. He had been told that the top three priorities for the consortium were entities in The Copper River Valley, the Mat-Su, and one to be built in Kenai.

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Commissioner Streur shared that the Mat-Su effort was largely driven by the South-central Foundation. He said both Kenai and the Copper River Native Association had

approached the state for funding for their respective facilities. He added that if the facilities are built they will have 20 years of operation costs paid for by the federal government.

Co-Chair Stoltze wondered whether savings would be realized because of the higher reimbursement rate for tribal health entities.

Commissioner Streur replied that every patient, and every service that was diverted for an Alaska Native into a native facility, received double reimbursement from the federal government.

Co-Chair Stoltze wondered whether the numbers could be quantified.

Commissioner Streur explained that currently 40 percent of native services were reimbursed at 100 percent. He said that the goal was to substantially increase those services. He believed the state could double the amount of native services.

Ms. Poppe-Smart interjected that the native services reimbursement amount was \$208 million.

Ms. Poppe-Smart addressed the second bullet on Slide 19. She stated that 1 in 5 Alaskans was covered by Medicaid, 40 percent of which were Tribal Health beneficiaries, and 40 percent of that received their care within the Tribal Health system. She believed this left a lot of opportunity to enhance the Tribal Health participation. She stated that she had attended the Alaska Native Tribal Health Consortium where she learned that the federal government, through Indian Health Services (IHS) funding covered 50 percent of health costs. She said that Medicaid was the partner that could help to make up the other 50 percent. She stressed that there was significant dialogue between the department and IHS. She explained that Tribal Health beneficiaries, like Medicaid beneficiaries, continued to maintain a choice on where they received their health care. She said that the department supported ongoing efforts to provide choices in rural areas.

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Ms. Poppe-Smart said innovations in the area of long-term managed care had been seen in other states, as well as changes in dual eligibility. She said that because of Alaska's small Medicaid population the department could observe changes made in other states and then only incorporate the best ideas. She stated that many states were moving toward the deinstitutionalization of long-term care residents; community based care was already a trademark of the Alaska Health Care Delivery System.

Ms. Poppe-Smart noted Slide 20 which addressed technology: operational efficiencies and care delivery implications. She noted that more efficiencies lead to higher enrollment. She said that the department was working on the claims payment system with the expectation of enhanced efficiencies by spring 2012, as well as the incorporation of additional metrics to allow for better management and observation of overall quality. She said that there were a number of technology initiatives across the country that looked into increased compliance efforts and searches for fraud using software. She relayed that the department hoped to be able to manage health care through technology systems that allowed for access to real-time health information across systems.

Ms. Poppe-Smart pointed to Slide 21 related to the maximization match, collections and refinancing opportunities. She said that the plan was to replace state funding with federal funding where allowable and to seek out Tribal Partner opportunities.

Representative Keller requested that the department be watchful for other health care facilities. He expressed concern that the supply of care could negatively impact other health care providers.

Ms. Poppe-Smart agreed that the conversation was important for all parties involved.

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Ms. Poppe-Smart moved to "Accounting and Recovery Collections" on Slide 22. She stated that the department collected third party liability if a Medicaid recipient also had access to insurance.

Ms. Poppe-Smart continued to Slide 23, which highlighted the Medicaid Task Force. She relayed that the request for proposal for the Medical Home had been responded to and that the department was in the process of evaluating the responses. She said that four pilot sites had been estimated. She shared that the initial estimates had been pretty slim with a savings of approximately \$165,000 per 1,000 lives. She estimated that the numbers would rise as the program matured.

Ms. Poppe-Smart discussed the Care Management Program on Slide 24:

- Care Management Program - expanded element of medical home with focus on recipients at highest risk who offer the greatest potential for improvements in both health outcomes and enhanced funding/cost avoidance.
  - Estimated cost of avoidance: Enhanced FMAP for 8 quarters for each participant. Conservative savings estimate of \$1,040,000 for 7,500 participants.

Ms. Poppe-Smart addressed Slide 25 which discussed Pharmacy Initiatives:

- Increased substitution to generic medications
  - Phase 1: Q2 \$1,250,000 cost avoidance annualized at \$5,000,000
- Increased Generic Medication through edits/PA
  - Phase 1: 6 months \$1,405,938 cost avoidance annualized at \$2,810,000
- State Maximum Allowable Cost
  - Fully implemented: \$500,000 cost avoidance annualized at \$5.5-\$6 million
- Enhanced preferred Drug List - not implemented
  - Estimate cost avoidance analysis underway.
- Psychiatric Medication Policy - not implemented
  - Estimate of cost avoidance \$182,000 - right care.
- Pharmacy initiative cost avoidance through Q2: \$4,655,938 annualized to \$13,310,000 - \$13,810,000

Ms. Poppe-Smart stated work was being done on the enhanced preferred drug list. She stated that the list had not been implemented but that discussions alone had resulted in cost avoidance. She shared that appropriate psychiatric medication administration for children in state custody had been under discussion in light of concerns about metabolic dysfunction that occurred when multiple psychiatric medications were administered.

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Co-Chair Stoltze discussed the estimate of cost avoidance on slide 26. He thought that it could be dangerous to limit access to needed psychotropic drugs.

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Ms. Poppe-Smart responded that the initiatives were about providing the right care to patients and not about limiting care to anyone. She stressed that the plan was to provide a consultant to help with the administration of sometimes 5 to 7 different psychotropic drugs at a time.

Commissioner Streur explained that the issue had been delayed due to the emotion surrounding the issue.

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Ms. Poppe-Smart concluded with Slide 27:

- Community First Choice - home and community based personal care services. Consultant engaged, design discussions and viability analysis underway.
  - o Estimate of cost avoidance: Enhanced FMAP of 6%.

Ms. Poppe-Smart shared that the Affordable Care Act estimations could not be calculated until the United States Supreme Court ruled on the constitutionality of the act.

Commissioner Streur emphasized that the Supreme Court ruling would provide some answers as to how ACA would affect Medicare/Medicaid in the state.

Co-Chair Stoltze asked if the department could hypothesize, independent of a Supreme Court rule, how ACA would affect the Medicaid budget.

Commissioner Streur replied that he could not separate the two. He stressed that absent the ruling the department did not know the impact of the expanded Medicaid coverage.

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Co-Chair Stoltze thought that the department would have had concerns about ACA, given that Governor Parnell was litigating the legislation.

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ADJOURNMENT

[10:35:17 AM](#)

The meeting was adjourned at 10:35 AM.