

04/04/13
PRESENTA-
TION:
ALASKA
HEALTH
WORKFORCE
COALITION

<TARGET><BILL></BILL><SUBJECT>04-04-13 PRESENTATION
ALASKA HEALTH WORKFORCE
COALITION</SUBJECT><COMM>HHSS28</COMM></TARGET>

Alaska Health Workforce Coalition

»» April 4, 2013

Kathy Craft ~ Delisa Culpepper
Nancy Merriman ~ Katy Branch

Alaska Health Workforce Coalition

- ▶ A public–private partnership created to develop, implement, and support a statewide approach to ensure a robust workforce to address Alaska’s growing health care needs
- ▶ Planning group consisted of industry, state government, University of Alaska

Alaska Health Workforce Coalition

LEADERSHIP

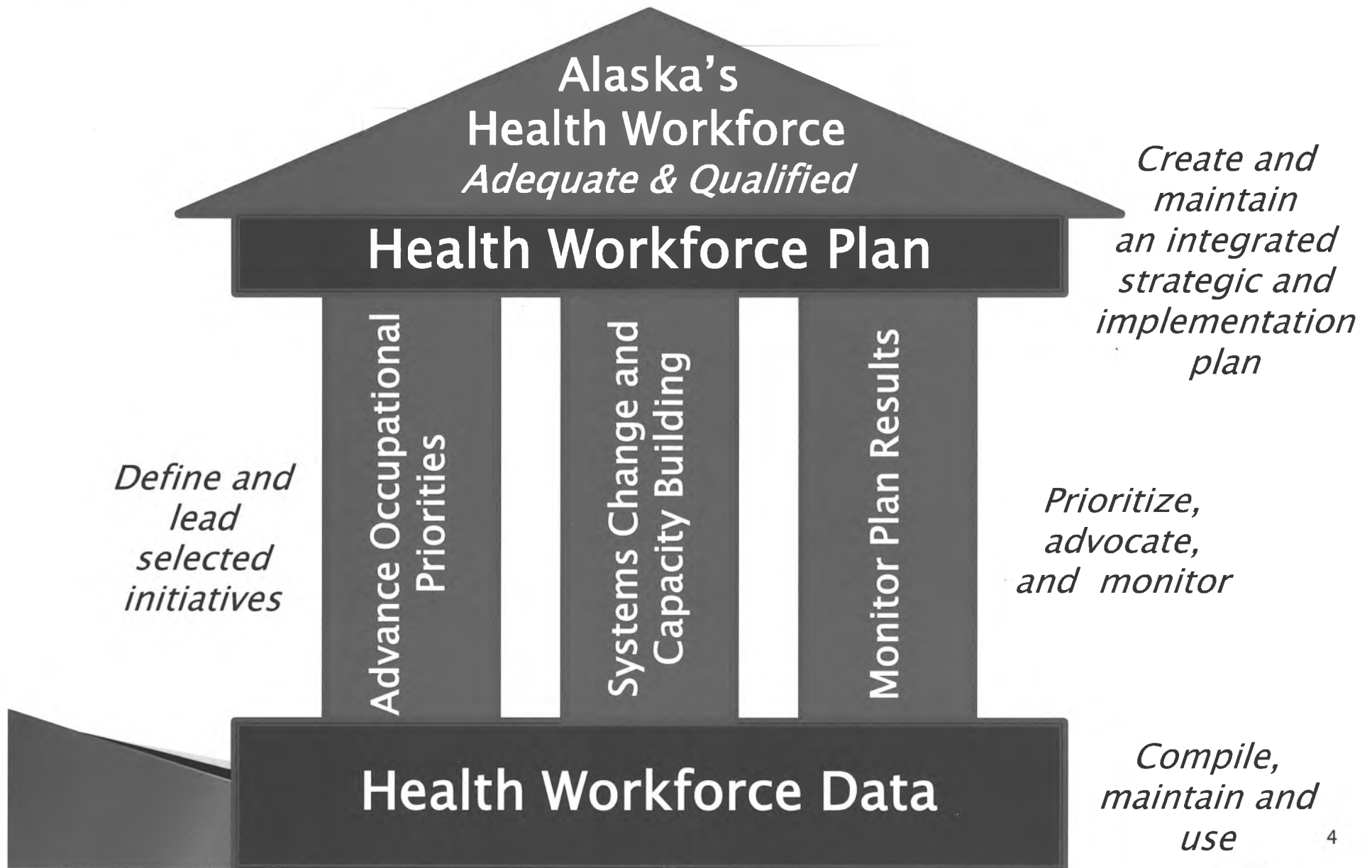
Industry

- AK State Hospital & Nursing Home Assn
- AK Primary Care Assn
- AK Native Tribal Health Consortium
- AK Workforce Investment Board
- AK Health Education Ctr
- AK Behavioral Health Assoc.

State of Alaska

- The Trust
- University of Alaska
- DHSS
- DOLWD
- DEED

Coalition Approach



Priority Occupations Determination

- ▶ Planning Process
 - Utilized data and information
 - Identified 35 critical need occupations
 - Engaged health related groups for prioritization
- ▶ 15 top priority groupings selected which included 26 occupations and professions
- ▶ An initial set of strategies for each occupation was developed for short, medium and long term

Engage – Train – Recruit – Retain

Environmental Factors

- ▶ Growing industry with ongoing shortages
- ▶ Affordable Care Act
- ▶ National recession easing – impacts recruitment
- ▶ Rapidly aging population and workforce
 - Higher demand for services
 - Pending retirements – faculty and providers
- ▶ Patient Centered Medical Home model
 - Chronic disease management
- ▶ Health Information Exchange/EHRs
- ▶ Cost of health care
 - Health employers / Business partnerships
- ▶ Loan repayment and incentives

Value-Added Health Services



Outcomes:

- Safe
- Effective
- Efficient
- Personalized
- Timely
- Equitable

Institute of Medicine

Value-Added Health Services

▶ Access

- Workforce – available, appropriate to meet growing needs
- Services where/when needed
- New models of care (such as Patient Centered Medical Homes)

▶ Quality

- Evidence-based services and care
- Educated Alaska workforce providing care continuity

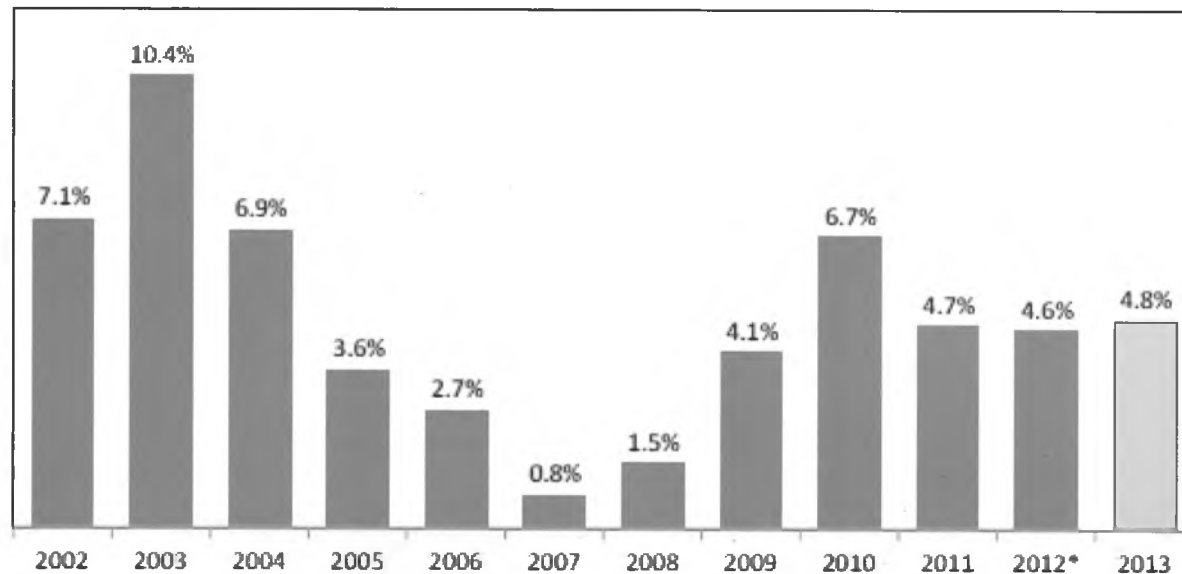
▶ Cost

- Working at the “top of the license” – use an array of technicians and professionals
- Grow our own health care workers – reduce recruitment costs and use of high-priced temporary professionals



Employment Growth

4 Health Care Continues to Climb Alaska, 2002 to 2013

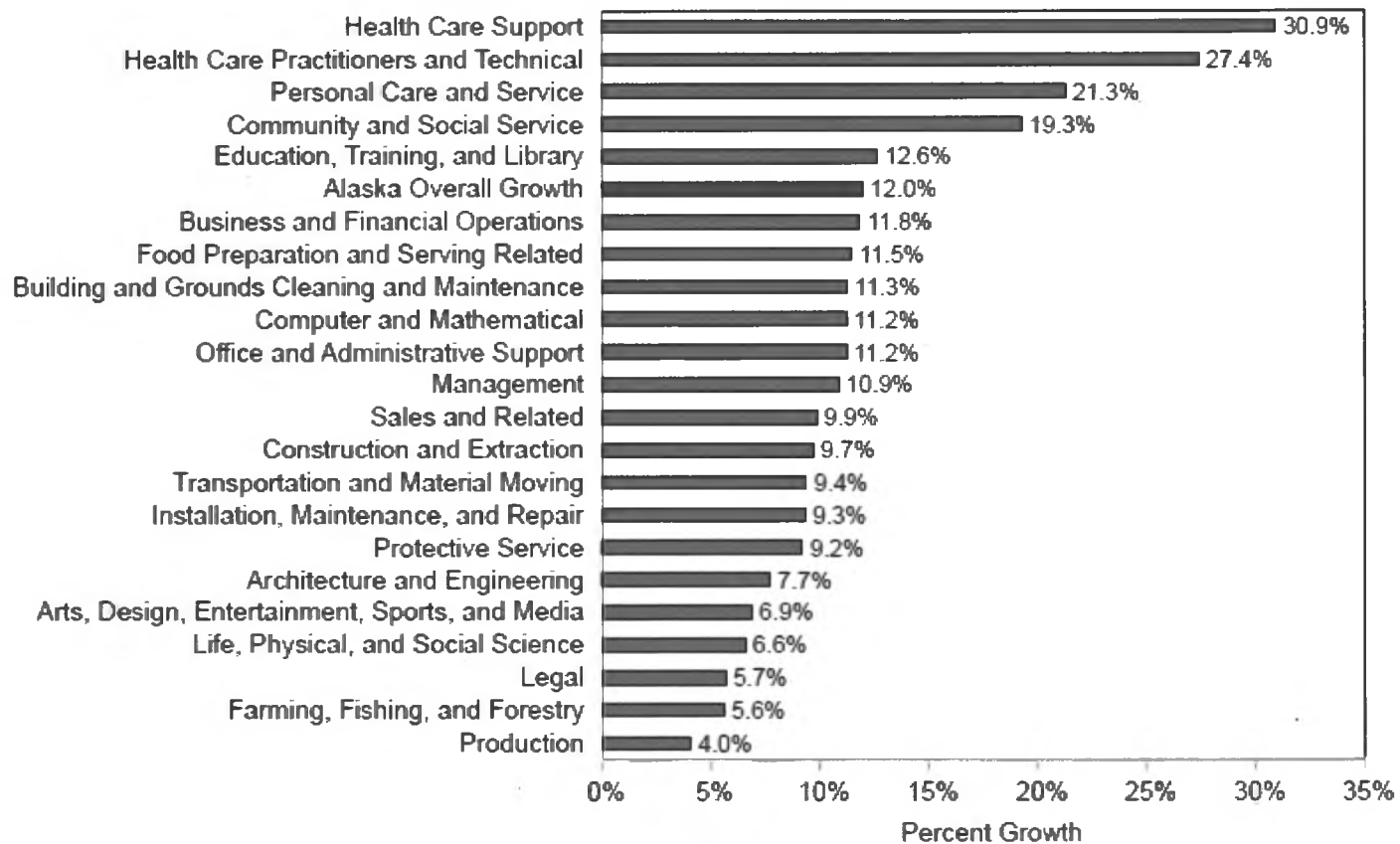


*Preliminary

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

Fast-Growing Jobs

Health Care Jobs to Lead Overall Growth **2** Alaska occupational categories, 2010 to 2020

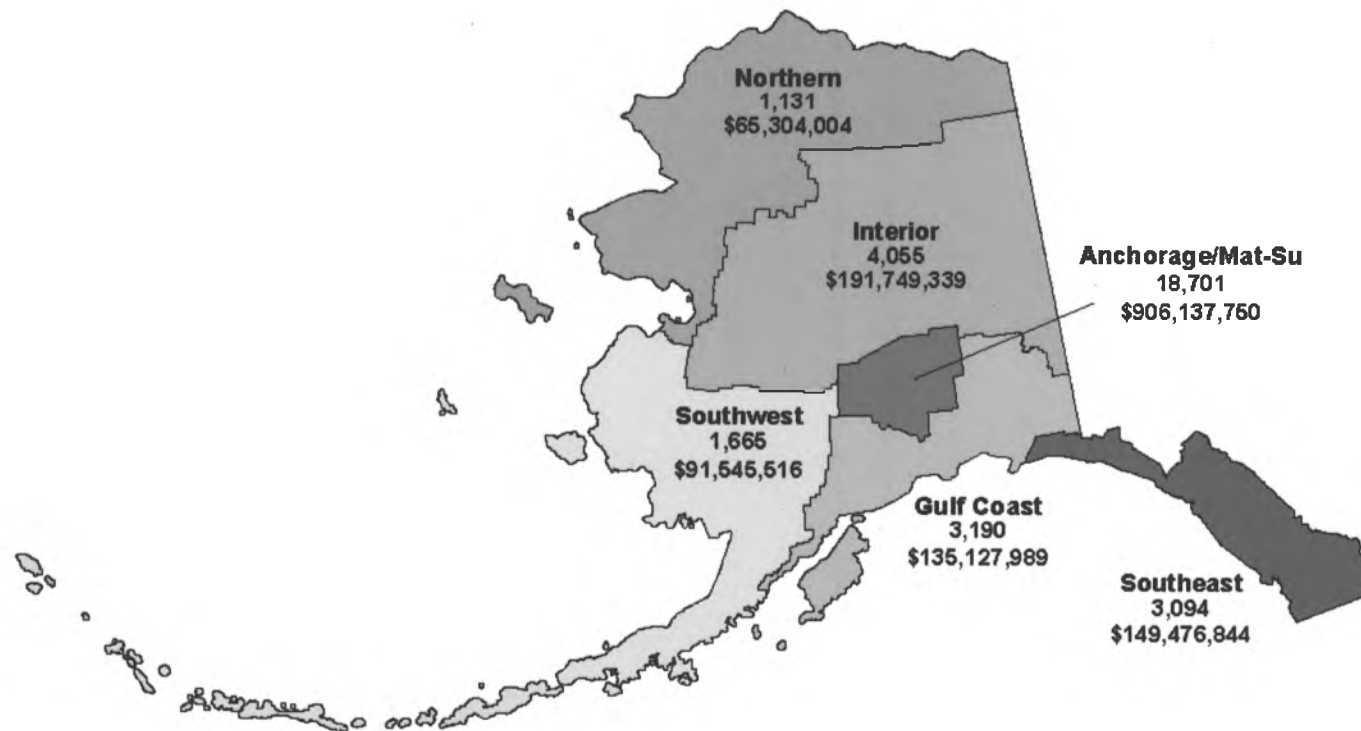


Note: Occupational categories are based on the federal Standard Occupational Classification Manual.
Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

Health Care Industry Impact

Health Care's Employment and Total Wages By economic region, Alaska 2010

10



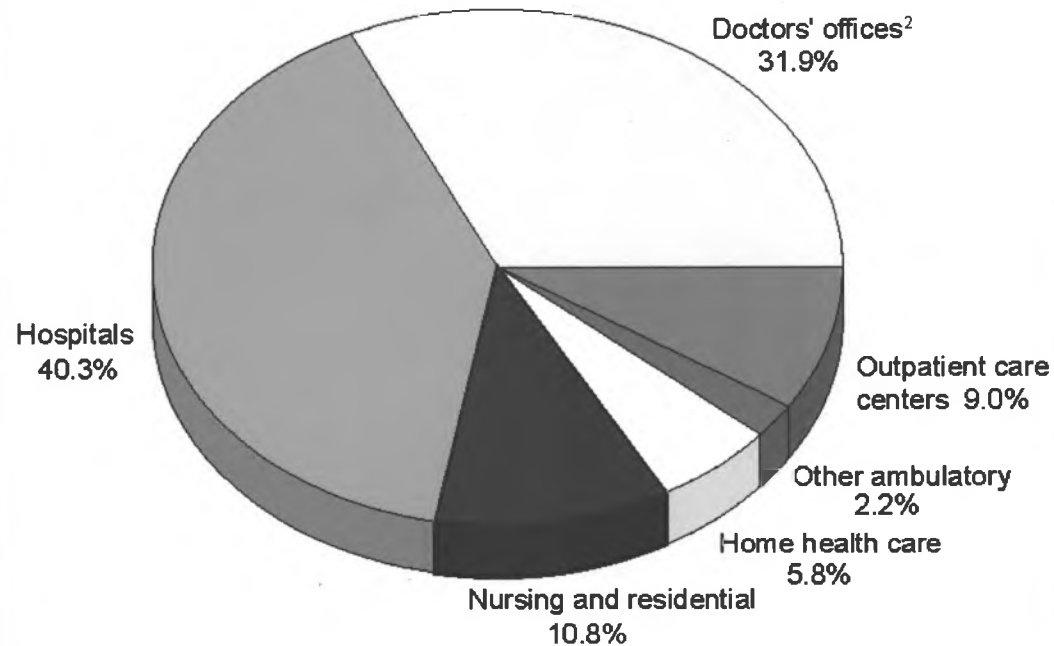
Note: Average annual employment

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

Job Locations

Where Health Care Jobs Are¹
Alaska, 2010

5



¹Includes private and public sectors

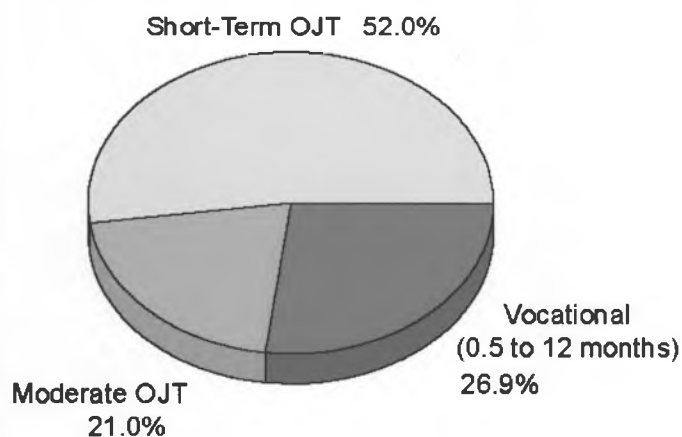
²Includes offices of physicians, dentists, and other health care practitioners

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

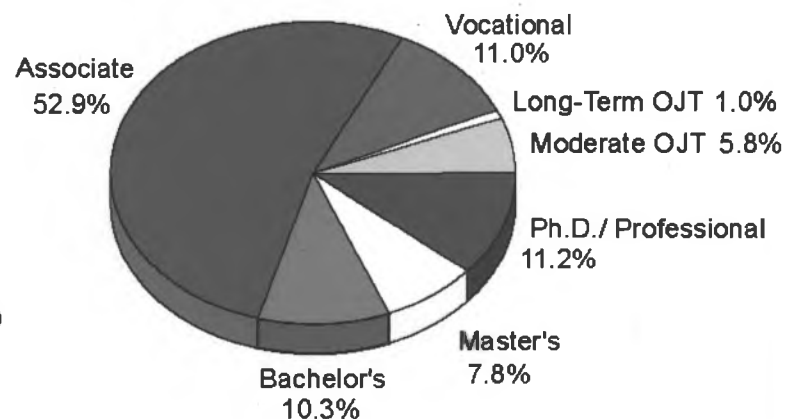
Preparing Health Care Workers

9 Training for Future Health Care Jobs¹ By required education level,² Alaska 2018

Health Care Support Occupations
Average Annual Wages = \$37,180 (2010)



Health Care Practitioner and Technical Occupations
Average Annual Wages = \$85,900 (2010)



Notes: Percentages do not sum to 100 percent due to rounding. OJT stands for "on-the-job training." Short term OJT is one month or less, moderate OJT is one to 12 months, and long-term OJT is more than a year.

¹Percentages are based on projected total openings in 2018 for health care occupations listed in Exhibit 8.

²Training levels are based on minimum training needed to get the position.

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

Action Agenda 2012–2015

Occupational Priorities

- Primary Care Providers
- Direct Care Workers
- Behavioral Health Clinicians
- Physical Therapists
- Nurses (Specialists, Educators)
- Pharmacists

Systems Change and Capacity Building

- Health Profession Loan Repayment and Incentive Programs
- Training and Professional Development
- Aligning regulatory policies that impact the health workforce
- Engage and prepare Alaskan youth for health careers
- Health workforce recruiting
- Health workforce data

Action Agenda Scorecard

- ▶ Quarterly review of the Action Agenda Scorecard conducted by the AHWC
- ▶ 12 Priorities
 - Each with 2–6 Objectives
 - Each Objective has clear outcomes, champions, and a target date for completion

Status Summary @ 3/21/2013	
Completed	6
On track	31
Not on track; need to address	5
Will not achieve; target goal missed	1

FY12 Successes

Legislative

- ▶ Loan Repayment and Incentives (HB78) bill passed
- ▶ Nurse Practitioner program funding
- ▶ Physical Therapist/Physical Therapist Assistant programs funding
- ▶ Funding for Perioperative Nursing program

Other Results

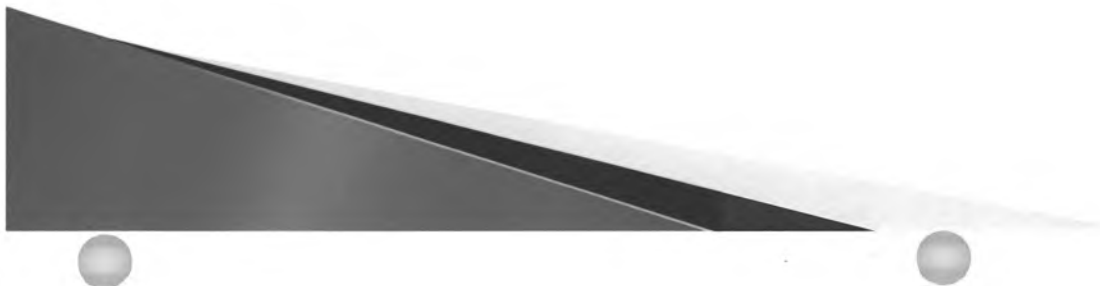
- ▶ Perioperative cohort graduation
- ▶ API funding for joint position with UAA
- ▶ Established bi-annual meetings between School of Nursing and ASHNHA CNOs
- ▶ AADSC website revised; now links to DOLWD sites
- ▶ Data needs and improvement opportunities determined
- ▶ Health Program of Study framework and implementation supported by grants from DOLWD/AWIB

2013 Advocacy Items

- ▶ **Alaska Area Health Education Center (AHEC)** – Katy Branch, Director, Alaska’s AHEC Program Office
- ▶ **Professional Development and Training** – Bill Hogan, Interim Dean of the UAA College of Health and Delisa Culpepper, Alaska Mental Health Trust Authority Chief Operating Officer
- ▶ **Complex Behavior Collaborative** – Reta Sullivan, LCSW, Division of Behavioral Health
- ▶ **Alaska’s Career Pathway / Program of Study Initiative** – Fred Villa, Associate Vice President for Workforce Development UA Statewide office and Cathy LeCompte, Chair, Alaska Program of Study Task Force and Associate Dean, UAA–CTC
- ▶ **Patient Centered Medical Home (PCMH)** – David D’Amato, Alaska Primary Care Association

Health Workforce Vacancy Study

- ▶ Vacancy Study was enhanced and made more comprehensive in 2012
- ▶ Alaska Standardized Health Occupations Taxonomy (AK SHOT)
 - Primary Goal: Crosswalk industry position titles with DOL Standardized Occupation Classifications (SOC) codes
 - Defines 164 occupations based on scope of practice
 - Provides “typical” minimum education requirements
 - Required the healthcare industry to critically evaluate and define our workforce and industry; not an easy task



Magnitude of the Data

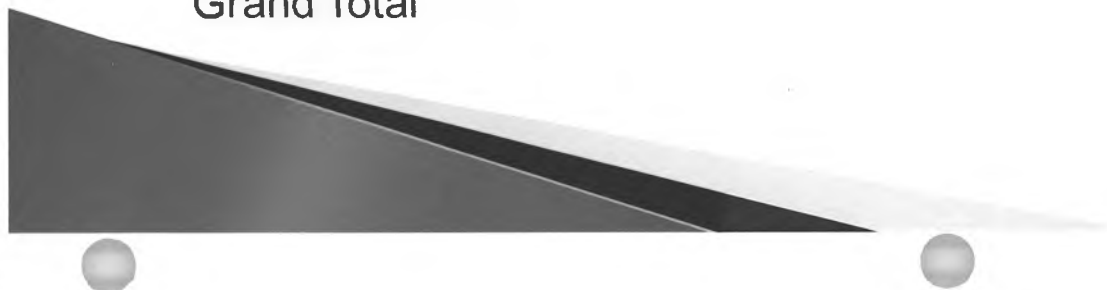
Health Workers by Region

Region	Grand total count of health workers by statewide	Count of health workers by region in the sample	Percent of health workers by region in sample
North	1237	1237	100%
Rural Interior	306	306	100%
Southwest	1510	1510	100%
Rural Southcentral=Gulf Coast	4411	3909	89%
Rural Southeast	2154	2154	100%
Fairbanks	3638	3127	86%
Anchorage/Mat-Su	22176	19647	89%
Juneau	1765	1765	100%
Grand Total	37197	33655	90%

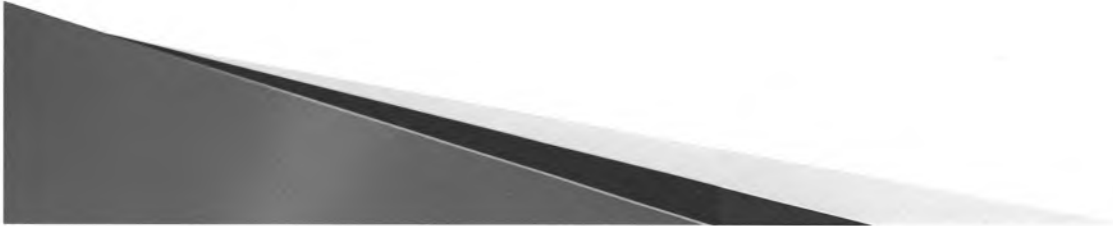
Magnitude of the Data

Health Workers by Industry Type

Industry Type	Grand total count of health workers by industry type, statewide	Count of health workers by region in the sample	Percent of health workers by industry group, in the sample
Ambulatory Health Care Services	13187	10971	83%
Hospitals	10171	10145	100%
Nursing and Residential Care Facilities	3194	2824	88%
Social Assistance	3814	3679	96%
Educational Services	566	553	98%
State Government	1257	1233	98%
Other Industries with Health Related Occupations	5008	4250	85%
Grand Total	37197	33655	90%



Anticipated Outcomes

- ▶ AK SHOT is being “tested” in the 2012 Vacancy Study; will be revised accordingly
 - ▶ Vacancy study results will be able to be trended; replicable methodology established
 - ▶ Closer relationship with the Department of Labor and Workforce Development (DOLWD) and other data partners
 - ▶ Data should indicate ongoing workforce trends and movements in occupations
 - ▶ Progress on the *Action Agenda* -> strengthened health workforce in Alaska
- 

Contact

- ▶ For AHWC information
 - Kathy Craft, Coordinator, AHWC
 - Kathryn.Craft@alaska.gov
 - 907-388-3501

**Alaska Health Workforce Coalition
Alaska Healthcare Mobilizes Long-Term Strategy to Address
Current Needs and Future Demand
Fall 2012 ~ Winter 2013**



<https://sites.google.com/site/alaskahealthworkforcecoalition/>

The Importance of the Alaska Health Workforce Coalition:

The Alaska Health Workforce Coalition (the Coalition) was launched to develop a coordinated, cohesive and effective approach to addressing the critical needs for health workers in Alaska. The Coalition recently published a 2012-2015 Action Agenda, outlining priority occupations and initiatives that require immediate attention to ensure Alaskans continue to have access to health care services. The Action Agenda is the implementation plan for the Alaska Health Workforce Plan 2010, endorsed by the Alaska Workforce Investment Board and many other groups representing state and industry health leaders.

What is the Alaska Health Workforce Coalition?

The Coalition is a public private partnership comprised of leadership representatives from government, health industry and associated organizations. The Coalition's leadership includes both industry and government entities:

- Alaska Native Tribal Health Consortium (ANTHC)
- Alaska Area Health Education Center (AHEC)
- Alaska Primary Care Association (APCA)
- Alaska State Hospital and Nursing Homes Association (ASHNHA)
- Alaska Workforce Investment Board (AWIB)
- Alaska Behavioral Health Association (ABHA)
- Alaska Mental Health Trust Authority (AMHTA)
- Department of Education and Early Development (DEED)
- Department of Health and Social Services (DHSS)
- Department of Labor and Workforce Development (DOLWD)
- University of Alaska (UA)

Why does the Coalition exist?

The Coalition exists to coordinate and monitor statewide healthcare initiatives and ensure strategic goals are met and system capacity is built through targeted action. When the Coalition formed in 2009, some coordination existed focusing on behavioral health, community based services and direct care workers through the Alaska Mental Health Trust Authority's (The Trust) Workforce Development Focus Area. However, little to no coordination and planning existed on the broader health workforce front, and the State lacked a plan to orchestrate the myriad efforts that were underway in health workforce development. Industry members recognized the need to focus on building communications and relationships that would allow for a coordinated

**Alaska Health Workforce Coalition
Alaska Healthcare Mobilizes Long-Term Strategy to Address
Current Needs and Future Demand
Fall 2012 ~ Winter 2013**



<https://sites.google.com/site/alaskahealthworkforcecoalition/>

approach. The Coalition came together to develop comprehensive picture of what was happening, what needed to be done and identify where additional resources were necessary to address the critical health workforce needs in Alaska.

What is the problem?

Alaska is expected to add 38,749 jobs between 2010 and 2020, an increase of 12%. Health care and social assistance which will support the needs of an aging population is projected to grow by about 31%. Health care and social assistance jobs will be booming through 2020 as the population of Alaskans age 65 and up is expected to grow by 89%. Ambulatory health care – which includes practitioners, outpatient care centers, and home health services – will gain 5,860 jobs, or 28%, and nursing homes and community elder care facilities will also show strong growth. The aging population will also increase social assistance, adding about 2,400 jobs – up 25% for the 10 year period. In all, health care and social assistance will be responsible for a third of the total added jobs over the projection period. It will also become a larger share of the state's employment, growing from 12.8% in 2010 to 15% in 2020.¹ Unfortunately, there are unacceptably high vacancy rates in many critical fields. The Coalition is orchestrating concerted and strategic tactics to address these needs through a comprehensive statewide plan.

Why are there shortages of health workers?

It's complicated. There are a large number of shortages in Direct Care Workers, who often provide needed services to the elderly, those experiencing mental health and additions problems, and those with developmental disabilities; Alaska experiences high turnover in these jobs. In addition, many of the shortages are in advanced health professions like Physicians, Psychiatrists, Physical Therapists, Advanced Nurse Practitioners, Licensed Clinical Professionals or Pharmacists. These require significant levels of advanced education, much of which is not currently available in Alaska. Many of the professionals that currently fill these positions are approaching retirement age and will be leaving their health professions. This is all complicated by the implications of the Patient Care and Affordable Care Act and the increasing number of Alaskans over the age of 65, both of which will increase the number of peoples seeking medical care.

¹ Alaska Economic Trends; Alaska Department of Labor and Workforce Development; October 2012, Vol. 32, No. 10, ISSN 0160-3345.

**Alaska Health Workforce Coalition
Alaska Healthcare Mobilizes Long-Term Strategy to Address
Current Needs and Future Demand
Fall 2012 ~ Winter 2013**



<https://sites.google.com/site/alaskahealthworkforcecoalition/>

What does the Coalition do?

The Coalition has identified 12 priority health occupation areas and meets periodically to review the progress on the strategies and implementation plan for these initiatives. They also work closely identifying areas that are ripe for cooperation and collaboration.

What are the priorities or goals of the Coalition?

The Coalition identified six occupations and six systems change and capacity building initiatives. These twelve priorities each have specific objectives to be completed through the end of 2015.

Health Workforce Coalition Action Priorities 2012-2015



How do I find out more?

Contact:

Kathy Craft

Alaska Health Workforce Coalition Coordinator

Kathryn.Craft@alaska.gov

907-388-3501 cell

<https://sites.google.com/site/alaskahealthworkforcecoalition/>

December 5, 2012

**Alaska Health Workforce Coalition
Alaska Healthcare Mobilizes Long-Term Strategy to Address
Current Needs and Future Demand
Fall 2012 ~ Winter 2013**



<https://sites.google.com/site/alaskahealthworkforcecoalition/>

December 5, 2012

ACA Impacts on Medical Care in Alaska, Exchanges and Medicaid Expansion

Ilona Farr MD

Lifelong Alaskan, Solo Practice, Head of 15 MD Call Group
of Independent Family Physicians Anchorage

Access to care

- ACA has added over 20,000 new pages of regulations to over 130,000 pages of pre-existing medical regulations before ACA. Makes care more expensive and more confusing to provide.
- 40% Providers opted out of Medicaid nationally creates more limited access (low reimbursement so less time with patient results in poorer outcomes, more rules, more restrictions, more audits)
- Estimates of up to 60% providers will retire or opt out of Medicare/Medicaid in next 3 years. Alaska has 80% participation in Medicaid now because of high reimbursement will fall if reimbursement cut and as more rules and regulations are released from committees set up under ACA.
- Many states really limit services/medications which causes poorer Medicaid outcomes. Medicare now won't pay for services ordered by un-enrolled providers. Exchanges-15- 60 page applications, limits on eligibility \$62,000/family of 2, expensive, limits on which insurance companies can participate, repayment if income higher than estimated
- More employers cutting back on employee hours <30/week or days <120/year of employment to avoid paying for rapidly increasing cost of health insurance premiums up over \$2000/year/family, or eliminating spousal coverage--Children covered up to 26 years. Severe penalties if do not supply insurance.
- HSAs modeled after Healthy Indiana Program much better option as lower costs, less fraud, better outcomes consider linking this to permanent fund could cover many more people less expensively putting patients back in charge of health care

Increasing Costs

- No state opt out once expand Medicaid. (see ACA)
- No federal funding guaranteed beyond first 3 years of Medicaid expansion
Federal government trillions in debt with (\$220?) trillion unfunded liabilities
Medicare, etc.(Baby Elephant model)
- Cost estimates range from \$68 to \$278 million/year just for cost to state for Medicaid expansion.
- CBO says 2014-2019 cost \$570 million to state of Alaska with cost increasing from 2014-2022 to \$987 million as federal reimbursement falls for Medicaid.
- Increasing premiums in private sector (Medicaid pays below cost- so costs shifted to private payers increasing the premiums especially for small businesses and individuals) as insurance premiums est. to increase by 30-70% and up to 200% for younger people. By 2018 est. 100% of private insurance plans in Alaska will be taxed at 40% level (More services mandated to be covered under ACA so premiums will go up)
- Expansion of Medicaid increases costs both to state and federal government paid for by increased taxes/fees/penalties on taxpayers and companies. (Block grants-RI which puts states in charge a better choice)

Problems with Medicaid

- Many who need help fall through cracks.
- Medicaid patients poorer outcomes (University of Virginia study 800,000 patients) than uninsured.
- Many not getting married or deliberately underemployed/unemployed to obtain Medicaid or coming from other states.
- 60% Alaskans now dependent on Fed government for services what about independence/freedom/personal responsibility? Small number actually paying the bill via taxes: federal government borrowing from foreign governments to pay bill is unsustainable!
- ACA transfers \$700 billion from elderly (Medicare) to fund younger healthier people (Medicaid/Exchanges) and requires everyone to pay for abortions and other elective procedures (sex change operations)
- Confusing rules/regulations fed/state takes decisions away from patients/providers and limits medications/services-- disallows charity care/ boutique practices!(providers are told they are committing fraud if discount services below Medicare rate)
- Low reimbursements/audits in many states forcing practices to close/sell to large corporations.

Exchanges

- Mandated under ACA --many from Medicaid may be forced into these exchanges- confusing requirements/60 page application!
- Expensive to run \$60 to 70 million to set up, \$6 million/year to run in Alaska alone before any care given --duplicate administrative costs Medicaid/exchange-- restrictive on who can participate people limited by income to 400% poverty level and insurance companies government controls which ones participate.
- No clear guidelines as Governor Herbert of Utah said unsure if their exchange will qualify!
- Federal exchange no penalties to private companies if do not meet insurance requirements as there are in state exchanges as ACA is currently written
- Many states giving money back!
- Unsure number of people who will benefit or of cost to run- if employers drop coverage and pay less expensive penalties may be tremendous demand from new uninsured or may be very little demand as people may find it less expensive to buy as they do now privately- unsure how new premium taxes will impact these exchanges.

Providers

- Shortage of primary care providers now 50% MDs over 50; need 32 new/year, average 8 new MDs. 60% MDs considering retiring/opting out nationwide 2014/2015 (67% in an Anchorage survey I did of 400 providers)
- EHR increased time and expenses and security concerns (25% less efficient) \$1.5 million in fines if security breach
- Coding changes in 2014 (10,000 to over 80,000 codes)
- Audits by 18 organizations now with increasing fines regular includes new RAC Medicaid/Medicare audits (commission based/extrapolate) mandated under ACA
- Bundling of payments(have to bill hospital if within 30 days of hospital admission)/quality reporting/IPAB (Independent Physician Advisory Board sets rates and services allowed)
- Underpayment by Medicare, Medicaid , Insurance, Large corporations(United ,etc. now buying up practices) US average 40% MDs not taking Medicaid; dramatic reduction in private practices since ACA passed selling to large corporations
- Federal mandates/limits on services or required unnecessary services (breast cancer screening/PSA testing/Pap smears, etc.) 50% of my breast cancer patients diagnosed before age 50 yet limit Mammograms to >50!
- Abortion coverage; Formula restrictions; pre-authorizations; increasing regulations

Summary

- ACA is a very expensive tax and regulatory bill that is going to drive providers out of business, increase insurance premiums and have a very detrimental impact on the economy of Alaska.
- We need to limit Medicaid, encourage the use of HSAs, not fund state exchanges, limit rules and regulations that increase costs for all, limit punitive audits and make them educational, support programs for the training of medical providers, continue efforts toward liability reform, pass legislation to allow boutique practices, and support health care freedom acts that put the patient, not the government, back in charge of their health care.

Better Solutions than ACA

- Block grants for states for Medicaid (Rhode Island)
- Educational not punitive audits
- Preventive care and prevention of accidents, Internet and school educational programs on diabetes, blood pressure, lipids, diet. etc.
- HSAs to model after Healthy Indiana Program(67% reduction in expenditures)
- Allow tax right offs or waivers for charity care without accusations of fraud for providers; pass legislation to allow boutique practices
- Increase vocational education programs for home care for disabled/elderly, support WWAMI, PA, NP, Residency, Nursing, Dental programs
- Payment like VISA/debit cards
- Allow patients/providers to make decisions not government/insurance/committees/UN/court(tort reform!)
- Pass a Health Care Freedom Act

ACA Impacts on Medical Care in Alaska, Exchanges and Medicaid Expansion

Ilona Farr MD

Lifelong Alaskan, Solo Practice, Head of 15 MD Call Group of Independent Family Physicians Anchorage

Access to care

- ACA has added over 20,000 new pages of regulations to over 130,000 pages of pre-existing medical regulations before ACA. Makes care more expensive and more confusing to provide.
- 40% Providers opted out of Medicaid nationally creates more limited access (low reimbursement so less time with patient results in poorer outcomes, more rules, more restrictions, more audits)
- Estimates of up to 60% providers will retire or opt out of Medicare/Medicaid in next 3 years. Alaska has 80% participation in Medicaid now because of high reimbursement will fall if reimbursement cut and as more rules and regulations are released from committees set up under ACA.
- Many states really limit services/medications which causes poorer Medicaid outcomes. Medicare now won't pay for services ordered by un-enrolled providers. Exchanges-15- 60 page applications, limits on eligibility \$62,000/family of 2, expensive, limits on which insurance companies can participate, repayment if income higher than estimated
- More employers cutting back on employee hours <30/week or days <120/year of employment to avoid paying for rapidly increasing cost of health insurance premiums up over \$2000/year/family, or eliminating spousal coverage--Children covered up to 26 years. Severe penalties if do not supply insurance.
- HSAs modeled after Healthy Indiana Program much better option as lower costs, less fraud, better outcomes consider linking this to permanent fund could cover many more people less expensively putting patients back in charge of health care

Increasing Costs

- No state opt out once expand Medicaid. (see ACA)
- No federal funding guaranteed beyond first 3 years of Medicaid expansion
Federal government trillions in debt with (\$220?) trillion unfunded liabilities Medicare, etc.(Baby Elephant model)
- Cost estimates range from \$68 to \$278 million/year just for cost to state for Medicaid expansion.
- CBO says 2014-2019 cost \$570 million to state of Alaska with cost increasing from 2014-2022 to \$987 million as federal reimbursement falls for Medicaid.
- Increasing premiums in private sector (Medicaid pays below cost- so costs shifted to private payers increasing the premiums especially for small businesses and individuals) as insurance premiums est. to increase by 30-70% and up to 200% for younger people. By 2018 est. 100% of private insurance plans in Alaska will be taxed at 40% level (More services mandated to be covered under ACA so premiums will go up)
- Expansion of Medicaid increases costs both to state and federal government paid for by increased taxes/fees/penalties on taxpayers and companies. (Block grants-RI which puts states in charge a better choice)

Problems with Medicaid

- Many who need help fall through cracks.
- Medicaid patients poorer outcomes (University of Virginia study 800,000 patients) than uninsured.
- Many not getting married or deliberately underemployed/unemployed to obtain Medicaid or coming from other states.
- 60% Alaskans now dependent on Fed government for services what about independence/freedom/personal responsibility? Small number actually paying the bill via taxes: federal government borrowing from foreign governments to pay bill is unsustainable!
- ACA transfers \$700 billion from elderly (Medicare) to fund younger healthier people (Medicaid/Exchanges) and requires everyone to pay for abortions and other elective procedures (sex change operations)
- Confusing rules/regulations fed/state takes decisions away from patients/providers and limits medications/services-- disallows charity care/boutique practices!(providers are told they are committing fraud if discount services below Medicare rate)
- Low reimbursements/audits in many states forcing practices to close/sell to large corporations.

Exchanges

- Mandated under ACA --many from Medicaid may be forced into these exchanges- confusing requirements/60 page application!
- Expensive to run \$60 to 70 million to set up, \$6 million/year to run in Alaska alone before any care given --duplicate administrative costs Medicaid/exchange-- restrictive on who can participate people limited by income to 400% poverty level and insurance companies government controls which ones participate.
- No clear guidelines as Governor Herbert of Utah said unsure if their exchange will qualify!
- Federal exchange no penalties to private companies if do not meet insurance requirements as there are in state exchanges as ACA is currently written
- Many states giving money back!
- Unsure number of people who will benefit or of cost to run- if employers drop coverage and pay less expensive penalties may be tremendous demand from new uninsured or may be very little demand as people may find it less expensive to buy as they do now privately- unsure how new premium taxes will impact these exchanges.

Providers

- Shortage of primary care providers now 50% MDs over 50; need 32 new/year, average 8 new MDs. 60% MDs considering retiring/opting out nationwide 2014/2015 (67% in an Anchorage survey I did of 400 providers)
- EHR increased time and expenses and security concerns (25%less efficient)\$1.5 million in fines if security breach
- Coding changes in 2014 (10,000 to over 80,000 codes)
- Audits by 18 organizations now with increasing fines regular includes new RAC Medicaid/Medicare audits (commission based/extrapolate) mandated under ACA
- Bundling of payments(have to bill hospital if within 30 days of hospital admission)/quality reporting/IPAB (Independent Physician Advisory Board sets rates and services allowed)
- Underpayment by Medicare, Medicaid ,Insurance, Large corporations(United ,etc. now buying up practices) US average 40% MDs not taking Medicaid; dramatic reduction in private practices since ACA passed selling to large corporations
- Federal mandates/limits on services or required unnecessary services (breast cancer screening/PSA testing/Pap smears, etc.) 50% of my breast cancer patients diagnosed before age 50 yet limit Mammograms to>50!
- Abortion coverage; Formula restrictions; pre-authorizations; increasing regulations

Summary

- ACA is a very expensive tax and regulatory bill that is going to drive providers out of business, increase insurance premiums and have a very detrimental impact on the economy of Alaska.
- We need to limit Medicaid, encourage the use of HSAs, not fund state exchanges, limit rules and regulations that increase costs for all, limit punitive audits and make them educational, support programs for the training of medical providers, continue efforts toward liability reform, pass legislation to allow boutique practices, and support health care freedom acts that put the patient, not the government, back in charge of their health care.

Better Solutions than ACA

- Block grants for states for Medicaid (Rhode Island)
- Educational not punitive audits
- Preventive care and prevention of accidents, Internet and school educational programs on diabetes, blood pressure, lipids, diet. etc.
- HSAs to model after Healthy Indiana Program(67% reduction in expenditures)
- Allow tax right offs or waivers for charity care without accusations of fraud for providers; pass legislation to allow boutique practices
- Increase vocational education programs for home care for disabled/elderly, support WWAMI, PA, NP, Residency, Nursing, Dental programs
- Payment like VISA/debit cards
- Allow patients/providers to make decisions not government/insurance/committees/UN/court(tort reform!)
- Pass a Health Care Freedom Act

ALASKA FAMILY MEDICAL CARE LLC
ILONA FARR, M.D.

4045 Lake Otis Pkwy., Suite 201
Anchorage, AK 99508
Telephone : (907) 562-4045
Fax: (907) 562-4047



April 3, 2013

To Whom It May Concern;

Please do not expand Medicaid, as expansion will result in increased costs to the state and federal governments, increased taxes, and a decrease in services for the truly needy as funds will be limited in the future. There is no guarantee of future federal funding for Medicaid because of our national debt, and state funds for Medicaid will depend on future oil revenues.

The number of providers will decrease as a result of more regulation and lower reimbursement rates, as 40% of providers nationwide have opted out of Medicaid currently, a trend that will get worse with time as ACA or Obamacare goes into full effect. In addition, cost shifting and lower reimbursement under Medicaid will result in both higher insurance premiums and increased medical costs for the private sector.

Medicaid expansion is a mistake for Alaska as there is no opt-out in ACA, leaving future generations with an unsustainable financial burden. Medicaid was intended to help the disabled, people with cancer, needy children, and people who are unable to care for themselves. Expansion will encourage people to be underemployed, not get married, or manipulate the system in other ways as private sector health insurance premiums dramatically increase under ACA.

Health savings accounts modeled after Indiana's Healthy Indiana Program, or block grants like Rhode Island has done are ways to save money and expand coverage without indebting future generations by expanding Medicaid.

Sincerely,

Dr. Ilona Farr, M.D.

ALASKA FAMILY MEDICAL CARE LLC
ILONA FARR, M.D.

4045 Lake Otis Pkwy., Suite 201
Anchorage, AK 99508
Telephone : (907) 562-4045
Fax: (907) 562-4047

April 3, 2013



To Whom It May Concern;

My name is Ilona Farr, MD. I am a Family Medicine Physician who has been a resident of Alaska for 52 years and practiced medicine here for over 26 years. I am speaking out in favor of HB 173/ SB 49. As a physician I do my best to promote life and do not wish to pay for abortions that are not medically necessary as this results in the deaths of unborn Alaskan children with my tax dollars.

18 states now have passed legislation prohibiting abortions in the new state exchanges set up under Obamacare or ACA. ACA rules violate the HYDE amendment, thus it is vitally important that Alaska sets a clear standard for what is medically necessary now before the federal government imposes their definition.

I agree with most of the reasons listed, but would add the words "kidney infection with sepsis" as many women have kidney infections that are easily treatable during pregnancy so that is not a reason for an abortion. Mental health issues by themselves are not a reason for abortions nor are economic considerations. I have several patients with mental and severe physical disabilities, including one with schizophrenia, who have successfully raised children. Moreover, I have seen many women become depressed and turn to alcohol and drug use following abortions to numb the pain of killing their unborn child.

In my practice I have seen women commit suicide after having abortions, and other women die because of congenital heart disease when they became pregnant. I have seen women make the difficult decision when they have babies with congenital abnormalities about whether or not to continue to carry a child when they were developing complications related to pregnancy. These are rare exceptions (less than 4% of abortions) as most abortions are related to choice on the part of the mother and these should not be paid for with tax dollars. I also know of a person who developed breast cancer while pregnant and successfully underwent treatment while pregnant and both she and the baby are healthy. We need to get clearly worded legislation passed to limit tax payer funded abortion as there are many places in the world where abortions are forced upon women and we do not want that here in Alaska.

Please pass HB 173/ SB 49 as it is needed to clearly define and limit tax payer funded abortions to those that are truly medically necessary. Medicaid funds should not be used for elective procedures as this takes needed services away from patients who are disabled, have cancer, children, and those that are unable to care for themselves, the poorest among us, the true purpose of Medicaid.

Sincerely,

Dr. Ilona Farr, M.D.