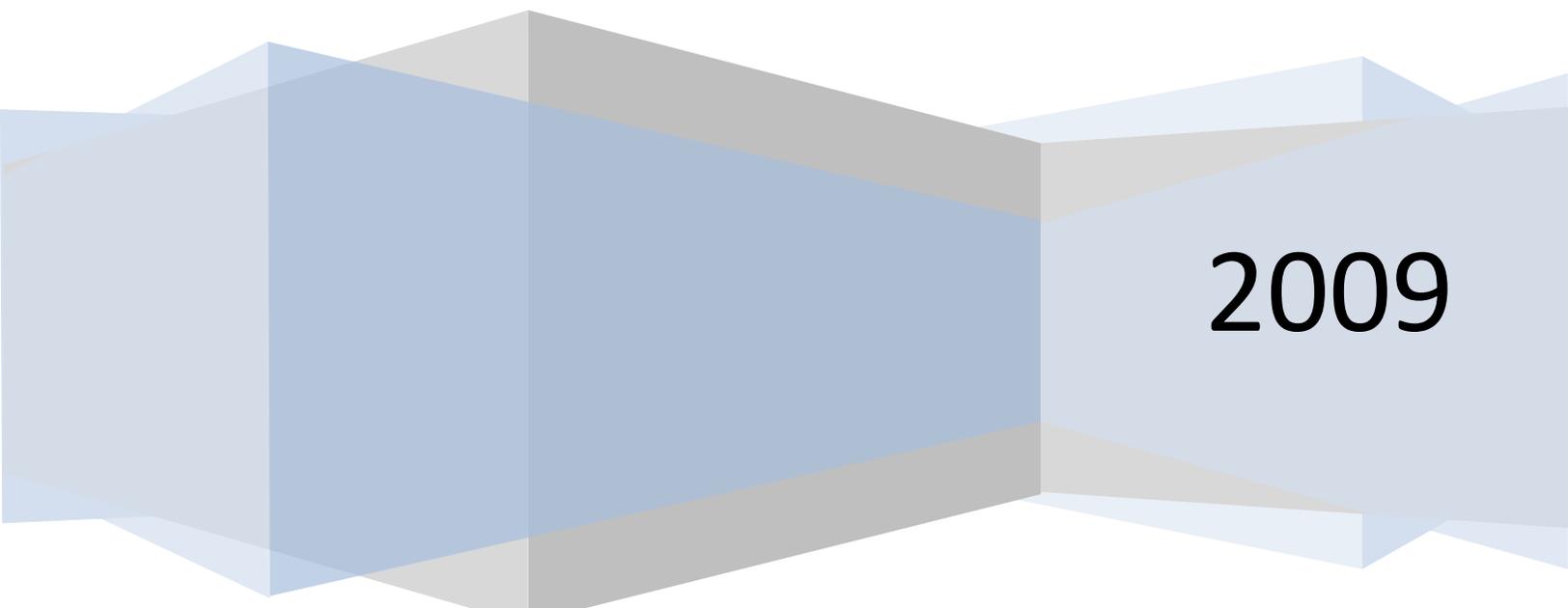


State of Alaska

Transforming Health Care in Alaska

2009 Report/2010 – 2014 Strategic Plan

Alaska Health Care Commission



2009

Insert State Seal and/or DHSS Logo

Transforming Health Care in Alaska 2009 Report/2010-2014 Strategic Plan

Alaska Health Care Commission

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Governor Sean Parnell and

The Alaska Legislature

Under Administrative Order #246

January 2010

Transmittal Letter from Chair and Director to Governor and Legislature

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Alaska Health Care Commission 2009 Report/2010-2014 Strategic Plan

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Executive Summary

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PART I: Introduction

A. Purpose of this Report

The purpose of this report is to convey the findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Administrative Order (A.O.) 246. This report is intended to serve as a five-year strategic plan for strengthening Alaska's health care delivery system, and is meant to be a living document that will evolve each year over the course of the coming five years as problems are studied, various approaches are analyzed, and implemented strategies are evaluated. This plan will be updated and conveyed to the Governor and Legislature in subsequent annual reports of the Commission if the Commission is continued beyond this first year.

Included in this report are:

- Part I: an introduction including background on the Commission, a summary of the Commission's 2009 activities, and a description of the Commission's vision, goals and values;
- Part II: information on the challenges of delivering and accessing health care in Alaska;
- Part III: the Commission's findings and recommendations for a series of immediate issues on which the Commission focused during their first year;
- Part IV: a brief explanation of additional areas of concern and potential improvement strategies identified this year that are recommended for future study in subsequent years;
- Part V: the actual strategic plan elements – laying out a framework for the five-year plan, providing a suggested action plan for implementation of the Commission's 2009 recommendations, and setting the Commission's work plan for 2010;
- Appendices: Background information on health and health care in Alaska, and additional documents produced by Commission.

B. Background on the Alaska Health Care Commission

The Alaska Health Care Commission was established by Governor Palin on December 4, 2008 under A.O. 246 to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. The duties of the Commission as outlined in the Administrative Order are to:

- I. Serve as the state health planning and coordinating body;
- II. Provide recommendations for and foster the development of a:
 - A. Comprehensive statewide health care policy;
 - B. Strategy for improving the health of Alaskans that includes
 - i. Encouraging personal responsibility in prevention and healthy living for all residents of the state;
 - ii. A reduction in health care costs for all residents of the state to be below the national average;
 - iii. Access in communities of the state to safe water and wastewater systems;
 - iv. The development of a sustainable health care workforce in the state;
 - v. Quality health care being accessible for all residents of the state; and,
 - vi. Increasing the number of residents of the state who are covered by health care insurance; and,
- III. Submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the Commission's recommendations and activities.

Commission members were appointed by Governor Palin (with legislative representatives appointed by their respective bodies) January 27, 2009. Short biographies for each of the Commission members are included in Appendix D. The members of the Commission are:

Ward Hurlburt, MD, MPH¹: Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.

C. Keith Campbell: Representing Consumers; Retired; Seward.

Valerie Davidson: Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.

Jeffrey Davis: Representing Alaska's health insurance industry; President of Premera Blue Cross Blue Shield of Alaska; Anchorage.

Ryan Smith: Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of the Central Peninsula General Hospital; Soldotna.

Wayne Stevens: Representing the Alaska State Chamber of Commerce; President & CEO of the Alaska State Chamber of Commerce; Juneau.

Lawrence Stinson, MD: Representing Alaska health care providers; Anesthesiologist and co-owner of Advanced Pain Centers of Alaska.

Linda Hall (Ex-Officio): Representing the executive branch; Director of the Division of Insurance; Anchorage.

Representative Wes Keller (Ex-Officio): Representing the Alaska House of Representatives; Wasilla.

Senator Donny Olson (Ex-Officio): Representing the Alaska Senate; Golovin.

Creation of the Commission followed from the work of an earlier group convened by Governor Palin – the Alaska Health Care Strategies Planning Council – established under A.O. 232 in 2007. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans. The Council's recommendations included a strategy for creation of a permanent health planning commission established in state statute.

Governor Palin's issuance of A.O. 246 was meant to jump-start the Planning Council's recommendation for a permanent body while legislation to establish the Commission was pending in the Alaska Legislature. There are currently three bills under consideration by the legislature that would create a health care commission in statute – HB 25 (Hawker), HB 75 (Cissna), and SB 172 (Olson)². If one of these bills passes during the 2010 session and is signed into law by Governor Parnell, the work of the current Commission will continue, but potentially with a slightly different charge and different members. If none of these bills pass, and unless Governor Parnell extends the life of the Commission through Administrative Order, the work of this Commission will end, but hopefully their one year of work and this report will add some value to on-going efforts to strengthen Alaska's health care delivery system and improve the health of Alaskans.

¹ Dr. Jay Butler served as Chair of the commission through mid-June. Commissioner William Hogan assumed the role of Chair in June through September. Dr. Hurlburt was appointed Chair of the commission following his appointment as Chief Medical Officer of DHSS in September.

² A table comparing the purpose, duties and membership of the bodies that would be created under each of these bills and A.O. 246 is included in Appendix D of this report.

C. Summary of 2009 Activities

The Commission experienced a number of challenges during their first year, including lack of funding, turnover in the Chairperson's role, temporary reassignment of their one staff person, uncertainties caused by the efforts at the federal level to reform the nation's health care system, and unknowns about the future of the Commission itself. Despite these limitations the Commission was successful in analyzing a number of critical issues and developing the recommendations contained in this report.

The Commission focused this year on:

1. Developing a vision of a transformed health care system for Alaska, including goals and values for guiding decision making;
2. Defining a comprehensive health care transformation strategy;
3. Identifying, analyzing and developing recommendations regarding a few critical priority issues;
4. Outlining a 5-year strategic planning framework, including identification of:
 - a) a preliminary set of measures for tracking the performance of Alaska's health care system, and
 - b) issues and strategies for future analysis and policy recommendation development.

The Commission identified as their initial priorities for analysis and policy recommendation development for this year the following issues:

- The consumer's role in health care
- Statewide leadership for strengthening the health care system
- Health care workforce development, with a focus on the physician workforce
- Health information technology
- Primary care access for Medicare patients

2009 Accomplishments

Meetings and public hearings: During 2009 the Commission held four face-to-face meetings: February 27-28 in Juneau; and May 1-2, August 25-26, and November 6-7 in Anchorage. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend in person but interested in listening to the meeting or providing public testimony. A number of teleconferences were held during the year as well. Summaries of the meetings and teleconferences are included in Appendix D of this report. Four public hearings were held, three during the May, August, and November meetings, and one on December 14 through the Legislative Information Office teleconference system.

Administration: In their first months the Commission established meeting rules, a set of by-laws, a job description for the Executive Director, and appointed an Executive Director (initially hired by DHSS in February to expedite the first meeting of the Commission). A copy of the Commission's meeting rules, by-laws, and Executive Director job description are included in Appendix D of this report.

Communication and coordination: The Commission developed a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (<http://hss.state.ak.us/healthcommission/>). A listserv was established to maintain communication with system stakeholders and members of the public interested in receiving periodic updates. As an initial step toward assuming the health planning coordination role noted in the Administrative Order, the Commission compiled an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (in Appendix C).

Products: The primary product developed by the Commission is this, their first report to the Governor and Legislature, which includes the Commission's vision, values and goals; findings and recommendations on the priority issues noted above, and a planning framework for the next five years.

D. The Commission's Vision for Transformation of Alaska's Health Care System

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." Benjamin Disraeli

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and behavioral, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the state of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, some are private business. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment. A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of their consumers.

Vision

Alaska's Health Care System

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The first step this year in the Commission's journey toward transformation of Alaska's health care system was to design a picture of the ideal system. The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers' will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system will be sustainable.

Health Care Goals

- I. Improved Access
- II. Contained Cost
- III. Safe, High Quality Care
- IV. Prevention-Based

The Commission also identified four goals for a transformed health care system to support a targeted approach to identification of improvement strategies and performance measurement. The first goal is to improve access to 1) affordable health care insurance coverage, and 2) the services of a health care delivery system that is, itself, healthy. The second goal is to turn the curve on Alaska's medical inflation rate so that it is at least below the national rate, in order to contain cost growth. The third goal is to assure that health care services delivered in Alaska meet the highest quality and safety standards. The fourth goal is to focus on prevention, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and to control costs by reducing the burden of preventable illness and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission agreed to the following set of values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of: 1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.

Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.

Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.

Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.

Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care.

PART II: Health Care Delivery and Access Challenges in Alaska

The effort to transform Alaska’s health care system to achieve the Commission’s vision requires an accurate and complete understanding of the current condition of the system. A description of health care in Alaska – how it is structured, provided and funded – is included as Appendix A of this report. Here in Part II a discussion of some of the particular challenges associated with delivering and accessing health care in Alaska is discussed.

A. Challenges to Alaska’s Health

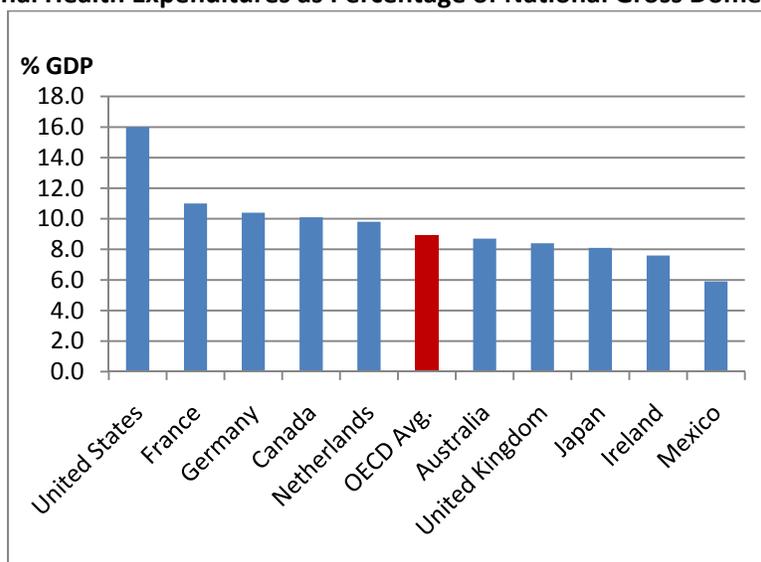
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B. The Cost of Health Care in the U.S. and Alaska

Cost of Care in the United States

Health care spending in the United States has been growing faster than the economy for decades, doubling from 8% of the nation's gross domestic product (GDP) in 1970 to 16% in 2006. It is projected to increase to 20% of GDP, with total spending doubling from \$2 trillion in 2006 to \$4 trillion, by the year 2016.ⁱ A comparison of national health expenditures in the United States to other member countries of the Organization for Economic Cooperation and Development (OECD)(Figure 1) illustrates the challenge our nation faces in maintaining a competitive edge in today's global market place, as the increasing cost of health care contributes to higher prices for goods and services produced in the U.S.

FIGURE 1: National Health Expenditures as Percentage of National Gross Domestic Product, 2009

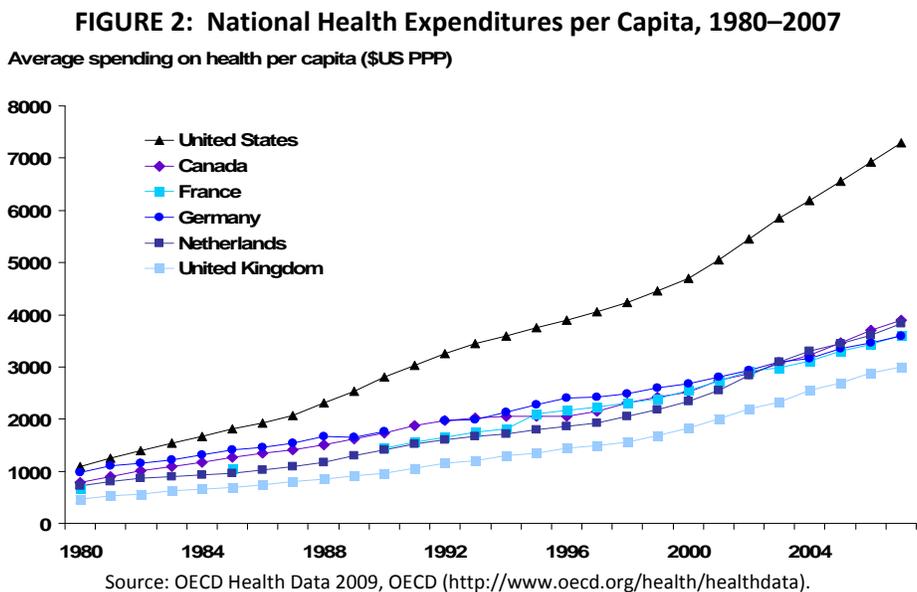


Source: OECD Health Data 2009, OECD (<http://www.oecd.org/health/healthdata>).

Higher costs in the United States do not necessarily reflect greater levels of health care resources. The U.S. has fewer physicians per capita than most other OECD countries, with 2.4 practicing physicians per 1,000 Americans compared to the OECD average of 3.1. The U.S. also has fewer hospital beds, with 2.7 acute care hospital beds per 1,000 Americans compared to the OECD average of 3.8 beds.ⁱⁱ Nor do higher costs mean that Americans have greater access to care. In 2004 97% of U.S. residents reported seeing at least one doctor in the previous 2 years, compared to 95% of Canadians and 98% of Australians. 84% of Americans reported having had a blood test, x-ray, or other diagnostic test in the past 2 years, compared to 84% of Canadians and 83% of Australians.ⁱⁱⁱ

Higher health care spending does not translate into better outcomes in terms of health status. Life expectancy and infant mortality are not necessarily reflective of the quality of health care, but are two general measures of population health that indicate Americans, for all the investment in health care services, are not healthier overall. Life expectancy in 2007 was at 78.1 years in the U.S., placing it 24th among the 30 OECD nations; and the U.S. ranked 28th in infant mortality at 6.7 per 1,000 live births, ahead of only Mexico and Turkey.^{iv}

Health care spending in the United States not only represents a higher proportion of our economy compared to other countries, average spending per person is significantly higher. Per capita national health expenditures in the United States increased 850% over the past three decades to \$7,290 (Figure 2). The average OECD national health expenditure in 2007 was less than half that amount, at \$2,984 per person.^v



Just one result of the escalation in health care costs is the impact on the personal finances of America’s families. In 1981 medical problems contributed to just 8% of personal bankruptcies in this country. By 2007 the share of bankruptcies attributable to a medical cause had increased to 62.1%.^{vi}

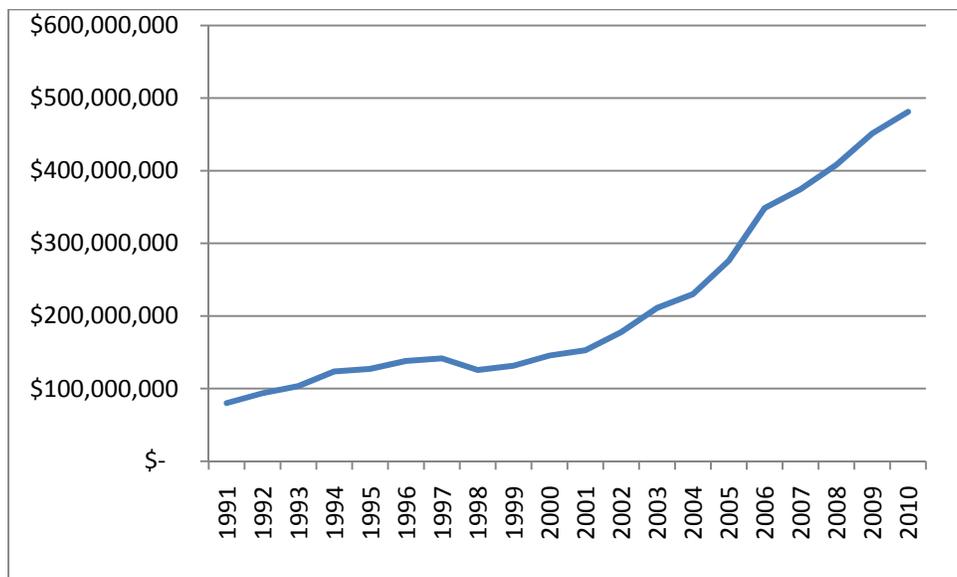
Cost of Care in Alaska

The rapid rise in the cost of health care in the U.S. is reflected in Alaska as well. In 1993 the Health Resource & Access Task Force, a group convened by the Alaska Legislature to address questions of health care cost and access, projected health care spending in Alaska would “sky-rocket” from slightly below \$1.6 billion in 1991 to nearly \$5.6 billion in 2003. The HRATF determined that this “alarming” level of spending was inevitable if nothing was done to change the status quo.^{vii} Today in 2009 estimated spending for health care in Alaska is over \$6 billion.

Government (all levels – federal, state and local) pays 64% of Alaska’s health care bill, including public insurance programs (Medicaid and Medicare), government employee and retiree insurance premiums, medical care for military personnel and dependents, Indian Health Service support of tribal programs, medical care provided through the Veterans’ Administration, grants to Community Health Centers, operation of the state psychiatric hospital and Pioneers’ Homes, and care for offenders incarcerated by the Department of Corrections. Private employers pay 17% of Alaska’s health care bill in the form of health insurance premiums, self-insured costs, and Workers’ Compensation medical benefits for their employees. Individual Alaskans pay the remaining 19% through premium contributions, co-payments, deductibles, and direct payment to providers.^{viii}

The high cost of health care presents a significant fiscal challenge for the state of Alaska. State government is currently responsible for administering over \$1.5 billion annually for all health care related expenditures (inclusive of costs for employees and retirees, Medicaid (including federal funds), a variety of grant programs, state health facilities, and services for inmates in state prisons). In 2004 Alaska had the highest annual Medicaid expenditure level per enrollee in the United States, at \$10,417.^{ix} State general fund expenditures for Medicaid grew from a little over \$80 million in FY 1991 to over \$408 million in FY 2008 – an increase of 410% during that 17 year period (Figure 3).^x

FIGURE 3: Alaska State General Fund Medicaid Expenditures, 1991-2010



Source: FY 2010 DHSS Budget Overview
 * FY 2009 and 2010 were estimated expenditures as of Nov 2008

Contributors to health care spending are numerous and varied, but there are two basic components driving total cost – price and utilization. Population increases and inflation are partly responsible for driving upward trends in utilization and pricing, but do not account fully for the rapid rise in health care spending in Alaska – which increased at an average annual growth rate of 8.9% per year between 1990 and 2005. Increased utilization due to a greater number of people living in Alaska made up 1.2% of the average annual spending increase, and general inflation contributed 2.4%. The reasons behind the remaining 5.3% average annual growth rate are not well understood.^{xi}

Increased utilization of the health care system is partly driven by the rising prevalence of health problems and the aging of the state’s population. It is also influenced by payment systems that do not present incentives for patients and providers to keep spending in check. New technologies that provide additional diagnostic and therapeutic opportunities are another factor. Also contributing to utilization that may be higher than necessary is the practice of defensive medicine due to concern over medical liability. Fraudulent claims for medical services never rendered also play a role. One factor that may be a key in understanding and controlling utilization is waste in the system – by some estimates as much as 30% of total health care costs are for medical goods and services that are not medically necessary or are ineffective.

Prices of health care services and medical equipment, supplies and pharmaceuticals make up the other component contributing to total spending. The higher cost of living in Alaska contributes somewhat to higher health care prices, but the Consumer Price Index (CPI) for Anchorage increased a total of 38% for all items between 1991 and 2005, while the CPI for medical care in Anchorage increased 98% during that same period. Lack of economies of scale due to Alaska’s small, widely dispersed population and also fragmentation and duplication in Alaska’s health care system are assumed to contribute to higher prices. Medical liability is a component of price, as the cost of malpractice insurance premiums is passed on to the consumer. New medical technologies also play a role in higher prices, as the cost to providers of implementation is passed on to consumers.^{xii}

One sign that the price of health care in Alaska is higher than in other states is the difference in reimbursement rates between Alaska and Washington State’s Medicaid programs. Many of the professional fees paid by Alaska’s Medicaid program are nearly three-times higher than those paid in Washington – Figure 4 provides just a few examples from the two states’ 2009 Medicaid Fee Schedule.

FIGURE 4: Differences in Medicaid Fees, Washington State and Alaska, 2009

| Description | Code | AK Fee | WA Fee | % Difference |
|---|-------|------------|----------|--------------|
| Outpatient Office Visit – Lower Level | 99212 | \$62.46 | \$22.69 | 175% |
| Outpatient Office Visit – Highest Level | 99215 | \$221.58 | \$76.00 | 192% |
| Emergency Department Visit | 99283 | \$109.14 | \$37.48 | 191% |
| Knee arthroscopy/Surgery | 29881 | \$976.77 | \$358.08 | 173% |
| Gall bladder removal, laparoscopic | 47563 | \$1,175.10 | \$412.29 | 185% |
| Cataract Surgery w/ lens implant | 66984 | \$1,141.23 | \$394.44 | 189% |

Source: Alaska Department of Health & Social Services, Division of Health Care Services, December 2009

Another indicator that Alaska’s health care prices are generally higher is a comparison of spending for inpatient hospital services. In 2007 the average hospital adjusted expenses per inpatient day was \$2,104 in Alaska – 24% higher than the national average of \$1,696.^{xiii} The average hospital cost per stay in Alaska was \$27,171 compared to the 2007 national average of \$15,455.^{xiv}

And one more example of higher prices and overall costs comes from the Workers’ Compensation program. Alaska has ranked 1st in the nation for cost of workers’ compensation premium rates since 2005. Medical costs made up 72% of total benefit claims in Alaska in 2008, compared to the national average of 58%. The average medical cost per workers’ compensation claim in Alaska was \$40,000 per injury in 2008 compared to the national average of \$26,000. Alaska’s Workers’ Comp medical fee schedule rates were the highest in the nation in 2006 – on average 3.5 times higher than Massachusetts, the state with the lowest rates.^{xv} Below are a few examples of fees paid by Alaska’s program compared to Washington’s and Hawaii’s.

FIGURE 5: Differences in Workers’ Comp Fees, Alaska, Washington and Hawaii 2006

| Description | Code | AK Fee | WA Fee | HI Fee |
|--|-------|------------|----------|----------|
| Outpatient Office Visit – Mid Level | 99213 | \$127.00 | \$76.00 | \$61.00 |
| Radiology (MRI, spinal canal cervical) | 72141 | \$2,339.00 | \$769.00 | \$634.00 |
| General Medicine (nerve conduction) | 95904 | \$219.00 | \$81.00 | \$66.00 |
| Knee arthroscopy/Surgery | 29881 | \$4,181.00 | \$869.00 | \$693.00 |
| Physical Medicine (therapeutic proc) | 97110 | \$83.00 | \$40.00 | \$32.00 |

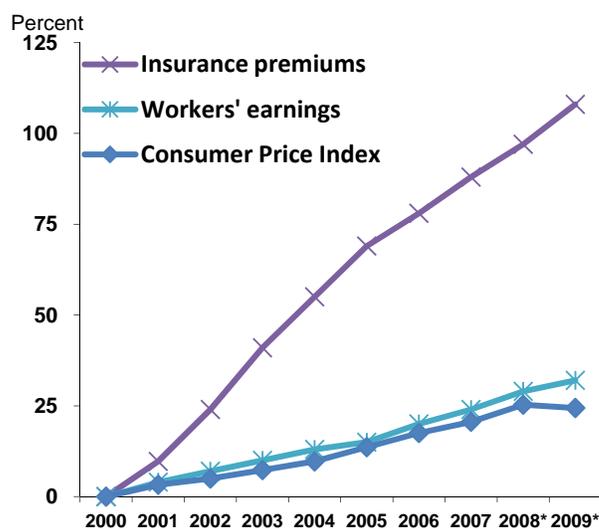
Source: November 2009 Report of the Workers’ Compensation Medical Services Review Committee, AK Dept of Labor & Workforce Development

More research is required to understand the disparity in health care prices between Alaska and other states. A more comprehensive analysis of fees paid by all major payers and programs should be conducted. An analysis of variations in fees paid within Alaska as well as comparisons to other states should be included. Note the example from the above two tables in the disparity between fees paid by two different Alaskan programs for the same procedure – Alaska’s Workers’ Compensation program pays a professional fee for arthroscopic knee surgery (CPT 29881) that is more than four times higher than the fee paid by Alaska’s Medicaid program. One other issue related to price and total cost that is not widely understood and should also be investigated is the difference between charges billed by providers and actual reimbursement levels, and how cost shifting occurs as providers adjust to changes in their payer mix and volume.

C. Health Insurance Coverage of Alaskans

Increased spending for health care translates into higher insurance premiums, as health insurance providers adjust to cover rising prices and growing utilization. Naturally therefore, as the overall cost of health care has increased over the years, the price of health insurance premiums has kept track. Unfortunately workers’ wages have not kept pace with the rise in the cost of health insurance (Figure 6), and health care-related expenses are consuming a larger proportion of Americans’ household income each year.

FIGURE 6: Premiums Rising Faster than Wages and Inflation
Cumulative Changes in Components of U.S. National Health Expenditures and Workers’ Earnings, 2000–2009



*2008 and 2009 NHE projections.
 Source: K. Davis, *Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums*, (New York: The Commonwealth Fund, Aug. 2009).

In Alaska health insurance premiums for working families grew by 90.8% between 2000 and 2009. In comparison, the median earnings of Alaska’s workers rose 17% during the same period. The average annual insurance premium for family health coverage in Alaska rose from \$7,456 in 2000 to \$14,226 in 2009. The average annual premium for individual health coverage rose from \$2,923 to \$5,626 during that same period.^{xvi} The percentage of income spent on health care in Alaska (based on per capita averages) increased steadily from 11% in 1991 to 19% in 2004.

14% of Alaskans are uninsured or do not have access to military, Veteran’s Administration or Indian Health Service-funded health care services. The following table (Figure 7) illustrates the proportion of Alaskans covered by various types of health care coverage.

FIGURE 7: Health Insurance Coverage by Type of Coverage in Alaska and the U.S.

| Health Insurance Coverage Type Average for data years 2006-2008 | Alaska | | United States |
|--|----------------------|--|------------------|
| | Count | Percent of Total | Percent of Total |
| Covered by Any Source | 547,203 | 81.8% | 84.5% |
| Employer | 388,381 | 58.0 % | 59.0% |
| Individual (self-purchased) | 42,891 | 6.4 % | 9.0% |
| Medicaid & Denali KidCare | 78,636 | 11.8 % | 13.4% |
| Medicare | 57,384 | 8.6 % | 13.9% |
| Military/VA | 88,944 | 13.2 % | 3.7% |
| <i>Indian Health Service only</i> | <i>Recalculating</i> | <i>To</i> | <i>Break</i> |
| <i>Uninsured all year</i> | <i>Out</i> | <i>IHS</i> | <i>Bens</i> |
| Total | 668,917 | (percentages add up to more than 100% because of overlapping coverage types) | |

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009; Adjusted to include as “covered” people of Alaska Native/American Indian race who may have access to IHS-Funded services.

84% of uninsured Alaskans belong to households with one or more workers. Most uninsured workers are self-employed, or employed by small businesses that do not offer health benefits or offer coverage they cannot afford. While nearly all firms with more than 100 employees provide health benefits, less than a quarter of Alaska’s smallest businesses (those with fewer than 10 employees) offer health insurance. The seasonal nature of Alaska’s workforce is an important factor in employer health coverage. The CPS survey data in the Figure 7 table does not capture Alaskans who only have coverage part of the year in the reported uninsured amount. It also does not account for Alaskans who are underinsured – those who have coverage but with such high deductibles and co-pay that they still face financial barriers to health care.^{xvii}

D. Health Care Delivery System Challenges

Alaska experiences many health care delivery challenges, including the logistical difficulties and costs involved in providing care for a relatively small number of people spread over vast geographic distances, a delivery system that is highly fragmented, and an inadequate supply and distribution of health care workers.

Logistical Challenges

Alaska is the largest state in the nation geographically, encompassing an area greater than the next three largest states – Texas, California and Montana – combined. At the same time Alaska's population is among the smallest of the states. Alaska has the lowest population density in the U.S. with 1.2 persons per square mile compared to the U.S. average population density of 79.6. 26.1% of the state's population lives in communities of fewer than 2,500 people.^{xviii} The dispersion of such a small number of people over such a large area increases the difficulty and cost of delivering care here.

Approximately 75% of Alaska's more than 300 communities are not connected by road to a community with a hospital. Nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft.^{xix} Transportation costs are high – air travel between a village and the nearest community with a hospital generally costs more than \$100, with airfare from some of the more remote villages to the tertiary care centers in Anchorage costing as much as \$1,200. Geography and harsh weather conditions pose additional transportation barriers, and can be especially problematic in an emergency situation.

Transportation is not just an issue in terms of patients' ability to reach needed services. The cost of moving supplies, staff and equipment required to operate clinics and hospitals in rural Alaska can be formidable. For example, the price of heating fuel and gasoline in the most remote communities of the state reached as high as \$10.00 per gallon this year – the cost of transporting the fuel to these communities was higher than cost of the fuel itself.^{xx}

The cost of delivering services is also made higher by a loss of economies of scale associated with operating hospitals in sparsely populated regions and clinics in nearly every small community in the state – a necessity due to the remoteness and isolation of those locations. Some of Alaska's smallest communities with a clinic have as few as 50 residents. However, the loss of economies of scale to maintain the facilities is off-set somewhat by the innovative workforce solutions used to staff them, such as the Community Health Aide/Practitioner Program, and the use of telehealth technologies. Many of Alaska's most rural facilities are also highly subsidized by the federal government.

System Fragmentation and Duplication

Alaska's health care "system" is not a system, but an assortment of private, for-profit and non-profit, large and small medical businesses; hospitals and clinics to serve military personnel, retirees and their dependents; and hospitals and clinics owned and operated by tribal organizations. Health care organizations within the same sector (military, tribal health system, or private sector) do not have interoperable electronic information systems, care coordination systems, or business management processes. In addition to fragmentation in the delivery of services, there are a variety of payers financing health care services, including Medicare, Medicaid, private insurers, self-insured employers, the military and VA, the Indian Health Service, and individuals.

Alaska has benefited from a strong military presence due to the state's strategic location, a strong tribal health system presence, and decades of representation in senior leadership in the U.S. Senate. Because of these three factors the federal government has played a lead role in development of Alaska's health care system, especially in rural Alaska as well as for medically underserved Alaskans statewide. And all Alaskans, not just the targeted service population, benefit from the presence of these services in communities where there might not otherwise be any health care delivery system. For example, the tribal health system provides care for non-Native individuals in remote communities where there are no other health care providers.

The downside of heavy federal investment in building the health care infrastructure is there are some communities that have multiple health care systems operating side-by-side. For example, one community of 9,000 people has both a community hospital and a tribal health system hospital. Another community of just 6,000 people has a community hospital, a tribal health system clinic, and a military clinic. Alaska's largest city, with a relatively small population of 285,000, has four hospitals – one military, one tribal, one for-profit, and one non-profit (plus two psychiatric hospitals). The facilities in these communities also serve regional (and in the largest city's case statewide) populations, but there is still an overabundance of infrastructure that leads to higher costs.

The duplication and fragmentation in Alaska's health care "system" is inefficient, and potentially unsustainable in the long-run if mechanisms for improved coordination and perhaps integration where appropriate are not implemented.

Health Care Workforce Shortages

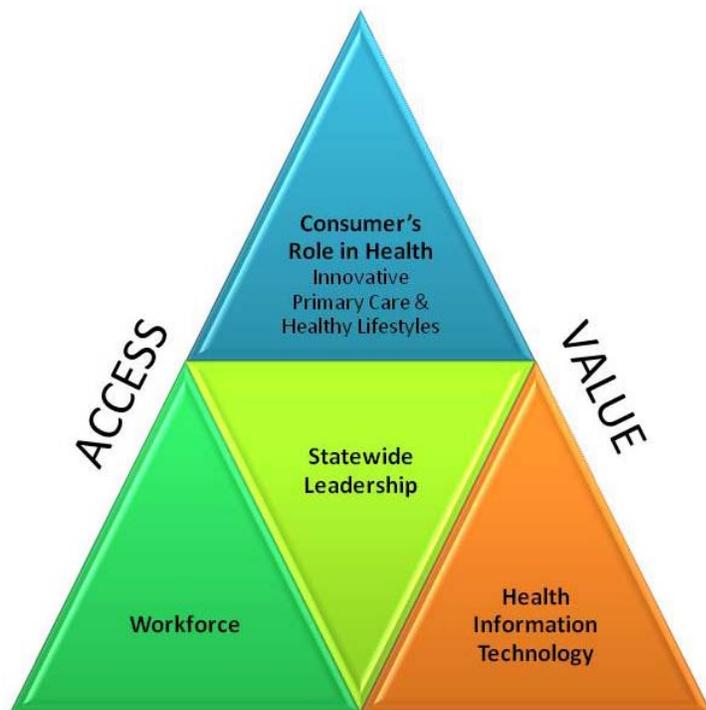
Demand for health care workers rose sharply over the past decade. Alaska's health care employment sector experienced 40% job growth between 2000 and 2007, compared to 13% for all other industries, outpacing the state's population growth during that same period by five times.^{xxi} The supply of new workers produced by Alaska's training and education programs plus those imported from outside Alaska cannot keep up.

Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations are experiencing vacancy rates of 15% - 20%. Pharmacist, therapist and certain nurse specialist positions are also experiencing high vacancy rates. Behavioral health occupations have a somewhat lower vacancy rate overall, but made up the highest proportion of vacancies with 1,033 vacant positions in 2007.^{xxii}

The costs health care organizations incur associated with recruitment and contracting for the services of temporary employees to cover vacancies is high. 80 Alaska health care organizations surveyed in 2005 reported spending \$24 million in the preceding year for vacancies in 12 key health occupations.^{xxiii} At least a portion of these costs may be passed on to consumers and insurers in the form of higher prices.

Delivery of health care is dependent on an adequate supply and distribution of qualified health care workers. 27 of Alaska's 30 boroughs and census areas contain federally designated health professional shortage areas. Staff shortages are one of the many challenges the Alaska health care delivery system is dealing with as it faces the future.

PART III: 2009 Health Policy Findings & Recommendations



PREVENTION-BASED Alaska Health Care Commission's Health Care Transformation Strategy

The Commission identified five priority issues for analysis this year:

- A. The Consumer's Role in Health and Health Care
- B. Statewide Leadership
- C. Healthcare Workforce
- D. Health Information Technology
- E. Access to Primary Care for Medicare Patients

Understanding and supporting the consumer's role in health care was a primary interest of the Commission's, and became the central focus of their strategic approach to transformation of Alaska's health care system. Over the course of learning and discussions two aspects emerged as critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered primary care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and a strong innovative primary care system depends. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to ensure Alaska's health care system is able to adapt to national health care reform, and to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

The fifth priority issue identified this year is not part of the comprehensive strategy, but was recognized as an immediate crisis worthy of special attention – the problem Medicare beneficiaries in urban Alaska are experiencing with access to primary care. This problem just may be an early indicator – “the canary in the mine” – warning us of the looming health care crisis in our state if we don't take decisive action.

A. The Role of Consumers in Health Care

1. Healthy Lifestyles

Finding A1a: Chronic disease is the leading cause of death and disability in the U.S. and Alaska.

Finding A1b: The majority of health care spending in the U.S. is for chronic disease.

Finding A1c: Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.

Finding A1d: Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.

Finding A1e: Childhood obesity is a growing concern; for example, 33% of kindergarten and 1st grade students in the Anchorage School District are overweight or obese.

Finding A1f: Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

1.7 million Americans die each year from chronic disease, which cause 70% of all deaths. Cancer, heart disease, stroke, and lung disease are four of the top five leading causes of death in Alaska. 133 million Americans – nearly half our nation’s population - live with at least one chronic condition. Individual health behaviors are the leading contributors to chronic disease. The World Health Organization estimates that 80% of heart disease, stroke and type 2 diabetes, and 40% of cancer, would be prevented if Americans stopped smoking, ate a healthy diet, and participated regularly in physical activity.

Complex medical care required over the prolonged course of illness and disability due to these conditions is costly. 75% of all health care expenditures are related to chronic disease. In Alaska, \$600 million is spent annually for hospitalizations due to heart disease and stroke, and \$419 million for all costs due to diabetes. The state of Alaska incurs an estimated \$9-10 million in medical costs due to obesity for state employees alone each year. The doubling in the prevalence of obesity in the U.S. between 1985 and 2004 accounted for nearly 30% of the increase in annual health expenditures.

It is not possible to address the escalation in health care costs without addressing the problem of chronic disease. The Commission began an inquiry into strategies known to be effective at supporting behavior change and learned about the success of Alaska’s Tobacco Program, which led to a reduction in adult smoking from 27% in 1991 to 22% in 2008. They also learned about successful worksite wellness programs. There is much more work to be done however - understanding what government, schools, work sites, and communities can do to support healthy choices requires on-going attention.

Recommendation A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

Recommendation A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.

2. Primary Care Innovation

Finding A2a: Patient-centric health care delivery models based on a longitudinal relationship-based platform are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care.

Primary care is the foundation of the health care delivery system – providing the main point of entry for secondary and tertiary care, and meeting the majority of patient needs for health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health conditions, and overall management of a patient’s health care services. There is increasing evidence that access to high-quality primary care improves health outcomes and reduces costs. However, the rising demand for services from an aging population and increasing chronic disease, coupled with the decreasing supply of primary care physicians, is sweeping our primary care system toward a crisis.

National health care reform discussions emphasize the importance of primary care, but tend to oversimplify the issues and solutions. Some suggest all that is required to improve access to primary care is increased reimbursement levels for primary care practitioners. Others suggest that primary care practitioners must be paid for additional services that are not currently reimbursable – those services they provide to assist with the coordination and management of a patient’s care and health conditions over and above the time spent during the actual patient encounter. Reimbursement is part of the solution, but increases need to come through a restructured payment system that supports and rewards practitioners for delivering patient care in a new way.

The Commission believes that strengthening the provision of primary care is the key to transformation of the health care system, but they also determined that the current primary care model is antiquated. The traditional medical model based on episodic acute care is no longer the most effective and efficient approach to meeting patients’ needs. They learned about a new patient-centered care model tried in our own backyard, the Southcentral Foundation’s Nuka Model of Care, that’s proven successful - demonstrating reductions in hospital days by 40% and emergency room and specialty visits by 50%.

The “Medical Home Model” is a term meant to describe the ideal concept for how primary care should be provided, but the Commission felt as though this term has become too much of a buzz word in the health care reform debates and that for many it simply implies paying primary care practitioners more for working in the same way. And so the Commission is avoiding use of that term, and is focusing on key characteristics of a modernized high quality primary care model:

- Patient and family centered
- Stable trusting relationship between care team and patient/family that continues over time
- Comprehensive, coordinated, and accessible care provided by integrated multidisciplinary teams
- Focus on health and wellness (physical, behavioral, social) rather than disease care

Alaskans need to be empowered to partner with their health care providers so they can be better stewards of their own health. This will require innovation in patient care at the primary care level.

Recommendation A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.

B. Statewide Leadership

1. Response to National Health Care Reform

Finding B1a: National health care reform proposals under consideration by Congress will have a significant impact on Alaska’s state and local governments, health care system, business community, citizens, and families.

Reform of the nation’s health care system has been a top priority for President Obama and congressional Democrats during 2009. The issue has been politically charged, with proponents stressing the importance of the increased access to health care coverage that would be afforded millions of Americans under the proposed reforms, and opponents decrying the increased national debt burden and inadequate attention to control of health care costs. At the core of the debate is a strong ideological divide over the appropriate role of government in health care.

Emotions are strong on both sides of the argument. The town hall meetings held by Alaska’s U.S. Senators this summer and fall drew thousands of Alaskans – many with stories of desperation related to inadequate access to health care, and many others expressing fear and frustration over federal intrusion into what they believe is a personal matter. There’s considerable misinformation and rhetoric from either side, with heavy use of popular media to attempt to sway public opinion. Over \$150 million has been spent on TV ads alone this year by both sides.

Unfortunately there is no one entity in Alaska responsible for objectively analyzing the potential impacts of various reform proposals on our state government, health care system, businesses, and citizens. The federal legislation currently under consideration will dramatically change the federal structure within which state health systems operate, and state governments will play a significant role in implementation of federal health care reforms if and when they pass. New responsibilities states can expect to inherit under federal reforms will be both financial and administrative.

State government will incur additional financial responsibilities if Medicaid expansion is mandated. The Alaska Department of Health & Social Services (DHSS) estimates the fiscal impact of the proposed Medicaid expansion at nearly \$450 million over a five year period. One considerable new administrative responsibility that appears likely is creation and operation of a state health insurance exchange. While many of the proposed changes are not slated to take effect until 2013 or 2014, a lot of work will be required during the interim to plan for implementation of new programs and systems.

Except for the ability to evaluate impacts of changes to Medicaid specifically, the state does not have capacity to analyze the effects of federal reform on our state. Regardless of whether federal reforms pass this year or not, the crisis in the nation’s health care system will continue to drive federal proposals that will require analysis that could be provided by some form of a state health policy infrastructure.

Recommendation B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.

2. Permanent State Health Planning Board

Finding B2a: The systems and policies for financing and delivering health care in Alaska are fragmented and complex, and the scope of the challenges involved in improving these systems is huge. Past efforts to improve health care in Alaska have been ad hoc in nature. A planning process to achieve health care system improvement must be sustained over time in order to ensure accountability for the achievement of meaningful change.

Over the two decades preceding the creation of the Commission, four groups have been formally convened to address the problems of access to and cost of health care. All of these entities were ad hoc in nature with a limited lifespan, meeting over periods ranging from 6 months to 2 years. They all had limited time to study the issues and develop recommendations, and in the end no real authority or accountability for following through on their findings and proposed strategies.

In 1987 Governor Cowper created The Governor’s Interim Commission on the Status of Health Care and the Health Care Industry in Alaska (“The Governor’s Interim Health Care Commission” for short) under Administrative Order #100. The Governor’s Interim Health Care Commission had 11 members and four staff, and held eight 2 to 3-day meetings over the course of nine months. The report they published in 1988 made 39 recommendations to the Governor and Alaska Legislature addressing insurance coverage expansion, access to long term care, cost controls, and state health planning.

In 1991 the Alaska Legislature created the Health Resources & Access Task Force. The 17-member HRATF held 14 monthly two-day meetings, producing a report calling for the creation of a single-payer system for Alaska. While their primary recommendation was never adopted, creation of a high-risk pool for Alaskans with pre-existing conditions who cannot otherwise obtain health insurance coverage – the Alaska Comprehensive Health Insurance Association (ACHIA) – followed from their work.

Ten years following the publication of HRATF’s final report in 1993, a private group – Commonwealth North – created the Alaska Health Care Roundtable to improve access, quality and cost of health care in Alaska. The Roundtable had a 17-member executive committee representing public and private sector interests. They produced a report in 2005 focused on the improvement of primary care.

In 2007 Governor Palin created the Alaska Health Care Strategies Planning Council under A.O. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans.

The two most recent groups recognized two problems with their ad hoc nature – 1) one year isn’t long enough to get a handle on the complexity of the problems in our health care system and come up with a comprehensive approach to solutions; and 2) there was no way to ensure accountability for their efforts. Both groups recommended that a permanent health planning and policy body be established in statute to provide sufficient time for gathering information, studying the issues, and developing comprehensive solutions. The Commission concurred with their recommendation.

Recommendation B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.

C. Health Workforce Development

1. General Workforce Development Findings & Recommendations

Finding C1a: Health care in Alaska is big business and represents a significant employment sector.

Finding C1b: Access to health care requires a sufficient supply and adequate distribution of health care providers. Successful achievement of the goal of expanding access to health care in Alaska is directly tied to health care workforce capacity and capability.

Finding C1c: Health care worker shortages in Alaska are widespread and costly.

Finding C1d: A comprehensive approach to health care workforce training includes strategies at every point on the training continuum (K12, post-secondary, graduate and post-graduate, on-the-job, continuing medical education).

Finding C1e: Alaskans have been particularly innovative in meeting their health care workforce needs.

Finding C1f: Many organizations, both public and private, have a stake in health care workforce development, and there are numerous programs and groups currently involved in health care workforce planning. There is evidence of collaboration in these planning and development efforts; however, not all related activities are fully coordinated.

Health care in Alaska is a six billion dollar industry, representing 16% of the state's gross domestic product.^{xxiv} It is also one of the biggest players in Alaska's labor market. With eight percent of the state's wage and salary jobs it leads all other industries except government, trade, and hospitality. Alaska's top employer is a health care provider – Providence Health & Services – employing over 4,000 people in 2008. Five of the top 20 employers in the state are health care organizations.^{xxv}

Health care is not only one of the largest employment sectors in Alaska, it is consistently the fastest growing. Between 2000 and 2007 the number of wage and salary jobs in the health care industry grew 40%, from 20,700 to 29,000, compared to just 13% for all other industries. Health care employment grew faster in Alaska than the U.S. overall, with 40% job growth compared to 19% in the U.S. from 2000 to 2007. Health care employment growth has outpaced Alaska's population growth rate by five times.^{xxvi} The Alaska Department of Labor & Workforce Development projects the health care industry will continue to expand in the next decade, increasing by 25% between 2006 and 2016 and adding twice as many jobs as any other industry.^{xxvii}

One other aspect of the health care industry important to the overall economy of the state is that there are health care jobs in virtually every community. There are at minimum paraprofessional health care providers in even the smallest villages. 23% of Alaska's health care workers are employed in rural areas.^{xxviii}

A functional health care system cannot be sustained without an adequate workforce. One key measure of access to health care is the supply of health care providers as a ratio to population. But having an adequate workforce goes beyond simple measures of supply. The workforce must be competent to provide high quality care that is culturally appropriate, must be literate in the use of health information

technologies, and must be able to adapt to new patient care settings and models that provide integrated, interdisciplinary, patient-centered care. Having an adequate statewide supply of well trained providers is not enough either – workforce distribution is an important factor as well.

Meeting the demand of Alaska’s health care industry for an increasing number of health care workers presents a significant challenge. The supply of new workers produced by Alaska’s training and education system plus those imported from outside Alaska cannot keep up. Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations (family physicians, general internists, nurse practitioners, physician’s assistants, and community health aide/practitioners) are experiencing vacancy rates of 15% - 20%. 19% of psychiatrist positions were vacant in 2007. Other occupations for which shortages exist include pharmacists (23.7% vacancy rate), therapists (physical, occupational, speech, and speech-language pathologists with vacancy rates ranging from 15.6 – 29.3%). Key nursing specialties also experience high vacancies, with a 23.4% vacancy rate for nurse case managers. Behavioral health occupations had a relatively lower vacancy rate at 13.9%, but made up the highest proportion of vacancies – with an estimated 1,033 vacant positions. In a 2007 survey of health care organizations conducted by the Alaska Center for Rural Health (and from which the above noted estimates are derived), 54% of respondents cited “inadequate pool of qualified workers” as the top reason for vacancies.^{xxix}

The costs associated with these vacancies are high. 80 Alaska health care organizations surveyed in 2005 reported spending \$24 million in the preceding year for vacancies in 12 key health occupations - \$11 million on recruitment costs plus \$13 million on itinerant temporary workers. They identified three main barriers to recruitment – locating qualified candidates, Alaska’s geographic isolation and harsh climate, and the need to satisfy the lifestyle and employment requirements of spouses and other family members.^{xxx}

The approach to replenishing the health care workforce as the numbers of jobs grow and workers are lost through retirement and attrition includes a combination of “growing our own” strategies – providing training and education in and for Alaska, and importing workers from outside Alaska through a variety of recruitment strategies. There is a history of collaboration in Alaska as the health care industry has partnered with the University system and state and federal funding agencies in the development of health care education and training programs in order to improve our ability to “grow our own.”

The University of Alaska (UA), the Alaska Legislature and Alaska’s health care industry have demonstrated a commitment to increasing in-state health career training and education opportunities in recent years. The number of students in UA health programs increased 68% between 2001 and 2008. In the fall of 2007 UA had 3,501 students enrolled in health programs. UA now has 80 health programs statewide in various fields including allied and behavioral health, emergency services, health management, medical office management, nursing, primary care, public health, and therapies. In partnership with the health care industry and with financial support from health care organizations and the state Legislature, the UA has recently added or expanded a number of programs, including:

- Doubling the nursing program to more than 220 AAS and BS admissions each year, and providing AAS nursing programs in 12 communities;
- Doubling the number of WWAMI medical school seats from 10 to 20;
- Addition of radiologic technology in six locations;
- Development of cooperative programs with outside universities for occupational, speech and language therapies and audiology;
- Expansion of the distance Master’s program in social work;

- Provision of rural allied health training via distance delivery;
- Doubling the Master’s of Public Health program to 70 distance students; and,
- Opening the Physician’s Assistant program (beginning July 2009).^{xxxi}

Training and education strategies do not begin at the post secondary level however. They include developing the pipeline of potential future Alaskan workers – reaching them early in their K12 education, making sure they have a solid foundation in math and science, and exposing them to potential careers in the health field. One program that helps young people explore health careers is the Area Health Education Center (AHEC). AHECs are federally and state funded programs meant to create formal relationships between university health programs and community partners to support health career education development. Alaska has an AHEC based out of UAA’s School of Nursing, administered by the Alaska Center for Rural Health, and serving four regions of the state through partnerships with the Yukon Kuskokwim Health Corporation, Fairbanks Memorial Hospital, the Alaska Family Practice Residency Program, and Southeast Alaska Regional Health Consortium. In addition to encouraging Alaska’s youth to pursue health careers, the AHEC facilitates clinical rotation opportunities and continuing education for health professionals in underserved areas. In addition to the AHEC program, Alaska’s WWAMI program and also the Alaska Native Tribal Health Consortium administer a number of health career development programs.

Training and education strategies do not end at the post-secondary level either. They also include post-graduate programs such as graduate medical education (GME) – residency programs for medical school graduates, and also non-physician programs such as clinical internships for Ph.D. psychologists. Alaska currently has one GME program, the Alaska Family Medicine Residency Program, and groups are in various stages of planning residency programs for pediatrics, psychiatry and internal medicine. Alaska lacks an internship for our Ph.D. doctoral students in psychology.

One other approach to addressing health care workforce shortages that must be noted – one for which Alaska is a proven leader – is innovation in the development of new types of workers and in the utilization of existing provider types. The extreme health care delivery challenges posed by the remoteness and isolation of many of Alaska’s Bush communities led to a unique workforce innovation in the middle of the past century that has become a model for other countries with similar challenges – the Community Health Aide/Practitioner. Alaska’s tribal health system has used that model to address behavioral health and oral health needs in more recent years, with the development of the Behavioral Health Aide and the Dental Health Aide Therapist Programs. Another innovation is Alaska’s use of mid-level practitioners – nurse practitioners and physician’s assistants – who have an expanded scope of practice to allow more independent practice by these providers than in many other states. Mid-level practitioners have played an important role in meeting the primary care needs of rural communities not large enough to support a physician practice in Alaska since the 1970s, and play an important role today in urban Alaska as well.

There are a number of collaborative health care workforce planning and development efforts currently underway. Following are some key examples:

- The Alaska Health Care Workforce Coalition (AHCWC) represents a large industry-led partnership that includes not only representatives of health care provider organizations, but also the three state government agencies that play an important role in health care workforce development – Health & Social Services, Education & Early Development, and Labor & Workforce Development, as well as K12 school districts, and the University of Alaska. This

Coalition is in the process of developing a statewide strategic health care workforce plan for Alaska under the auspices of the Alaska Workforce Investment Board (AWIB). A draft of this plan is currently being circulated for public comment, and will be finalized and submitted to the AWIB for endorsement in February 2010.

- The Alaska Diversified Economic Planning Team, established under Administrative Order #249 by Governor Palin, is in the process of developing a statewide strategic comprehensive economic development plan for the state (the “Legacy Plan”). This team has 16 different workgroups currently in the process of addressing various aspects of economic development. One of the workgroups is addressing health care, as it is not only a major employer and driver of Alaska’s economic engine; it is also an important support industry for other sectors of the economy. The Legacy Plan Health Care Workgroup, scheduled to produce a report in 2010, is primarily focusing on health workforce issues.
- Last year the Department of Health & Social Services (DHSS) established a position housed at UAF in the Office of the Associate Vice President for Health Programs and supported with funding from the Alaska Mental Health Trust Authority (AMHTA) charged with the responsibility for coordinating the numerous projects under AMHTA’s Workforce Development Initiative with DHSS and UA behavioral health workforce projects.
- The Trust Training Cooperative, housed in the University of Alaska Anchorage (UAA) College of Health and Social Welfare’s Center for Human Development, includes numerous partners focused on improving training coordination and availability for smaller and rural organizations servicing AMHTA beneficiaries. The Cooperative recently completed a behavioral health training needs assessment.

In addition to these various partnerships, coalitions and workgroups, there are a few entities that contribute routinely to research and analysis of Alaska’s health care workforce.

- The Research and Analysis Section in the Alaska Department of Labor & Workforce Development;
- The Section of Health Planning and Systems Development in the Division of Health Care Services, Alaska Department of Health & Social Services; and
- The Alaska Center for Rural Health housed at UAA.

These examples demonstrate that many private and public entities are invested in health care workforce development, but there is no one entity responsible for coordination of all these activities. A single organization charged with coordination of the many health workforce development activities in the state, and designated to provide the organizational home to support implementation of the statewide strategic plan currently under development by the AHCWC, is needed. This would help minimize the possibility that efforts might be duplicated and wasted, or that gaps in important aspects of workforce development go unaddressed. The designated entity could ensure that a comprehensive approach to meeting Alaska’s health care workforce needs is taken, including strategies to address:

- On-going assessment of Alaska’s health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of the health care workforce planning, development and support infrastructure.

Recommendation C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska’s health care reform and economic development agendas.

Recommendation C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.

Recommendation C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska’s health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.

Recommendation C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.

Recommendation C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.

2. Physician Shortage

Finding C2a: The United States is facing a shortage of physicians as this provider population ages and enters retirement and the production is not expected to keep up with demand. As the physician shortage increases in the U.S. the competition for recruiting physicians to Alaska will become increasingly difficult.

Finding C2b: Alaska has a shortage of primary care physicians³.

Finding C2c: New physicians face disincentives to entering primary care specialties.

Finding C2d: Providers stay to practice where they train.

Finding C2e: Mid-level medical practitioners (Nurse Practitioners and Physician’s Assistants) and medical support staff (nurses, medical assistants, care coordinators, etc.) are essential occupations for addressing primary care physician shortages.

There are many professions that make up the health care workforce and all are vital to a functional health care delivery system. The Commission chose to focus on the physician workforce in their first year, in part because the one specific health care delivery challenge they chose to study this year is the problem of Medicare access to primary care doctors. For their analysis of the physician workforce the Commission benefited from a recent study by the Alaska Physician Supply Task Force completed in 2006.^{xxxii} The Task Force was commissioned by the President of the University of Alaska and the

³ The Commission includes both osteopathic as well as allopathic medical doctors in their definition of physician. The Commission’s definition of primary care physician is slightly different from most standard definitions – family practitioners, pediatricians, and general internists are included, but also psychiatrists, and Ob-Gyns are excluded.

Commissioner of the Department of Health & Social Services to address questions regarding current and future need for physicians in Alaska, and to consider current and potential strategies for meeting estimated physician need.

The United States is experiencing a shortage of physicians which is expected to worsen as the baby boomer cohort of doctors enter retirement, the nation's population ages and requires more intensive medical services, and programs to educate new physicians have insufficient capacity to keep up with demand. A deficit of 96,000 to 200,000 physicians is projected nationwide by 2020.^{xxxiii} In 2006 the Association of American Medical Colleges recommended the number of medical school slots in the country be increased by 30% by the year 2020. As the competition between states increases for a decreasing supply of physicians, it has become increasingly difficult to recruit out-of-state doctors to move to Alaska.^{xxxiv}

The Physician Supply Task Force determined that Alaska has a shortage of physicians that is expected to worsen over the next 20 years. They estimated that Alaska should have 375 more physicians today, based on an assumption that Alaska should have 110% of the current national average physician-to-population ratio. The ratio of physicians to population in Alaska is 2.05 doctors per 1000 population compared to 2.38 doctors per 1000 population nationwide. Their recommendation was to increase the number of additional physicians practicing in Alaska each year from the current net average annual increase of 38 (78 new minus 40 lost to retirement and attrition) by more than 50%, to 59 net new physicians per year.

The Commission was impressed by the thorough and professional analysis conducted by the Task Force, but challenged a couple of the assumptions they used to derive estimates of current and future shortages in Alaska. One assumption the Task Force made was that the national average physician to population ratio is representative of the level of need. Another was that Alaska should have 10% more than the national average because of the structural inefficiencies in our state's health care system, and because of the additional administrative and supervisory responsibilities associated with support of paraprofessionals (Community Health Aides/Practitioners) and mid-level practitioners. The Commission felt that this assumption did not account for the fact that these other provider types relieve the actual direct patient care burden for those physicians, nor did it account for the expanded scope of practice of mid-level practitioners in Alaska that allows more independent practice on their part.

Because of questions regarding some of the Task Force's assumptions, the Commission was not prepared to agree at this time that Alaska faces a crisis in total physician supply, but conceded there is evidence pointing to a shortage of primary care physicians. The Alaska Center for Rural Health's 2007 Alaska Health Workforce Vacancy Study estimated a 20% statewide vacancy rate for general internists, a 19% vacancy rate for psychiatrists, and a 15.8% vacancy rate for family physicians. The problem Alaska's seniors are experiencing finding a primary care physician who will accept new Medicare patients is another indicator of this problem. These signs coupled with the Commission's strategic focus on developing and strengthening new primary care patient care models led to a determination that Alaska is experiencing a shortage of primary care physicians, and a recommendation that the state's limited public resources spent on physician supply development should be focused on increasing the supply of primary care physicians specifically.

A consideration of strategies to increase the supply of primary care physicians requires an understanding of the disincentives new medical school graduates face to entering primary care specialties. According to the Association of American Medical Colleges, the average educational debt of

indebted graduates of the class of 2008 was \$154,607, an increase of 11% over the previous year. 87% of graduating medical students carry outstanding loans, and 79% of graduating medical students have debt of at least \$100,000.^{xxxv} The high level of debt most new physicians have to bear poses a significant disincentive to choosing to enter a primary care specialty, as these are the lowest paid fields. Other disincentives beyond relatively low pay exacerbated by high debt burden include the practice environments that tend to require more work hours, more on-call time, and a higher administrative burden for generalists, and also the higher prestige that is often associated with practicing as a specialist as opposed to a generalist. A combination of strategies for improving education, recruitment, and supporting innovative practice models is required to address the need for an increased supply of primary care physicians.^{xxxvi}

Alaska is one of just 6 states that do not have their own medical school. Instead, Alaska participates in a collaborative medical education program, WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho), that provides a medical school opportunity to rural states in the northwest. Instead of paying to support an in-state medical school, the Alaska Legislature appropriates funds to pay the University of Washington for the government subsidy portion of the WWAMI medical school, which is approximately \$50,000 per student per year. In addition to the government subsidy, Alaska WWAMI students pay tuition of approximately \$20,000 per year (equivalent to Washington in-state tuition for UW medical students).

The number of medical student seats Alaska supports in WWAMI is set in state law (AS 14.42.033). Alaska supported 10 seats since the beginning of the program in 1971, but the legislature doubled support to 20 seats beginning with the 2007 school year. Even after this 2-fold increase, Alaska has less than half the national average medical school capacity. The U.S. average number of medical school seats to population is 26.6 per 100,000, compared to 11.9 for Alaska.^{xxxvii} The 30-member nation OECD average is 39.6/100,000.^{xxxviii} The Alaska Physician Supply Task Force recommended that Alaska expand participation in WWAMI to 30 and then eventually 50 seats.

The rate of return of Alaska WWAMI students to medical practice in Alaska is 47%, compared to the national average for all U.S. public medical schools which is 39%. Alaska medical students who participated in WICHE (Alaska's participation in WICHE medical school programs ended in 1995) had an 18% return rate. The actual return on investment for Alaska when the rate of return of all WWAMI students (including those entering Wyoming, Washington, Montana, or Idaho's program) to medical practice in Alaska is 88% of the number of seats Alaska has subsidized.^{xxxix} As far as quality, the U.S. News & World Report ranked WWAMI as the #1 medical school for primary care in 2009 for the 15th consecutive year, and also #1 for both rural medicine and for family medicine for the 17th consecutive year.^{xl}

The physician training pipeline ends with graduate medical education. Following completion of medical school, graduates have to complete a residency program in order to be licensed and practice in the United States. Residency programs vary in length. A family medicine residency is three years long. According to national studies physicians tend to stay and enter practice in the community where they complete their final residency training. Alaska was the last state in the nation to establish an in-state residency program, but since 1997 has had the Alaska Family Medicine Residency Program (AFMRP). The program expanded capacity from eight to 12 residency slots a few years ago. In the past 12 years AFMRP has graduated 75 family practice physicians. Of those 75 graduates, 80% have stayed to practice in Alaska, and over half of those who have stayed are practicing in rural Alaska. The AFMRP was designed to train physicians for practice in rural Alaska, so it is achieving its original goal.^{xli}

A number of other residency programs are being considered for Alaska and are at various stages in the planning process. A pediatric residency program is being planned by a collaborative group including Providence, the Alaska Native Medical Center, and a number of private providers. This program would be a branch residency program of the UW Children's Hospital Pediatric Residency Program, with residents practicing in Alaska for four months out of each of the three years in the program. A psychiatric residency program planning process is underway with financial support from the Alaska Mental Health Trust Authority. This program would also be a branch program of UW, which has already developed a similar branch model in Spokane and Boise (these two programs have been successful in terms of retaining residency graduates to practice in their communities). Psychiatric residencies are four years in length, and the Alaska branch program would have the residents spending their first two years in Seattle, and their last two years in Alaska. One other residency program under consideration is for general internal medicine, but an organized planning effort has not quite coalesced at this point due to lack of financial support and leadership.

One barrier to development of residency programs in Alaska is funding. Most residency programs receive a significant portion of their operational funding from Medicare, which since its inception in 1965 considered educational activities in teaching hospitals a reimbursable expense. Because of the substantial growth in costs associated with support of graduate medical education (GME) – which in 2007 cost Medicare \$8.8 billion – Congress imposed a cap in the Balanced Budget Act of 1997 on the number of residency positions Medicare could support. The cap was set at the number of residents who were training in a given teaching hospital as of December 31, 1996, and did not include provisions for making adjustments or redistribution based on need. This cap effectively locks Alaska out of the Medicare GME funding pool.^{xlii}

Medical education expansion is an important strategy for increasing primary care physician supply, but the time it takes to prepare a college graduate to practice medicine is a minimum of seven years. In addition to increasing capacity for education of new physicians, other strategies to improve recruitment and retention of physicians from outside Alaska must be considered. Support-for-Service programs offer an important recruitment and retention tool for states. These programs provide current or future health practitioners with educational scholarships, educational loans, repayment of educational loans, or direct monetary incentives in return for a contractual obligation with the practitioner to serve a period of service in a needy area.

Loan repayment and financial incentive programs are the most popular form of support-for-service programs, as studies document service obligations established at the beginning of a practitioner's educational process (through a scholarship or loan) are less effective in terms of achieving the desired recruitment outcome as are loan repayment and financial incentive programs. Another benefit of loan repayment and financial incentive programs is that the return is immediate. One study documented a service completion rate of 94% and 93% respectively for loan repayment and financial incentive programs, compared to 63% and 41% respectively for scholarship and loan with service option programs.^{xliii}

One last strategy the Commission considered for addressing the shortage of primary care physicians was the use of mid-level practitioners – physician's assistants and nurse practitioners – to help meet Alaska's primary care need. The recent support by the Alaska Legislature for establishing a PA training program at UAA is a significant step, but opportunities for expanding the use of "physician extender" occupations should be further explored.

Recommendation C2a: The Commission recommends that the Governor and Alaska Legislature target the state’s limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.

Recommendation C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.⁴

Recommendation C2c: The Commission recommends that the Governor and Alaska Legislature support an immediate increase in WWAMI seats from 20 to 24. Future expansion should be supported as resources allow. The WWAMI service requirement should be changed from 50% payback for not returning to practice in Alaska for 5 years, to 100% payback for not returning to practice as a primary care physician in Alaska for 5 years.

Recommendation C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.

Recommendation C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska’s congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.

Recommendation C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing “physician extender” occupations as an additional approach to addressing the primary care physician shortage.

⁴ The Commission’s recommendation that an educational loan repayment and direct incentive program be established for Alaska to assist with addressing physician shortage specifically is not meant to exclude other provider types for which shortages are documented from such a program.

D. Health Information Technology

1. General HIT Findings & Recommendations

Finding D1a: Development and utilization of electronic information management tools is essential to health care system improvement for the purpose of supporting:

- Increased health care efficiency and effectiveness; and
- Improved clinical quality and patient safety.

DRAFT UNDER DEVELOPMENT

Recommendation D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.

Recommendation D1b: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.

2. Health Information Exchange and Electronic Health Records

a) Development and Use of HIE/EHR

Finding D2a: Many providers in Alaska are at the early end of adopting electronic health records. Many still use paper records. Barriers to adoption of electronic health information technologies by Alaska's health care providers include:

- Start-up costs for new systems, including purchase of new hardware and software as well as costs associated with implementing new office procedures, training staff, and transitioning existing records from paper to electronic;
- The multitude of products on the market making evaluation and selection of one system time-consuming and costly for individual providers and small practices;
- Systems that are not user-friendly from the provider's perspective, i.e. are difficult, inflexible and time-consuming to use;
- Costs associated with on-going operation and maintenance; and,
- Antiquated and nonstandard eligibility and claims processing systems.

Finding D2b: Federal policies, such as the national incentive program funded under ARRA and pending Medicare payment penalties, are forcing rapid adoption of electronic health records by providers. Some Alaskan providers feel forced to move forward quickly while being concerned that standards are not yet fully in place and systems may not be ready.

DRAFT UNDER DEVELOPMENT

Recommendation D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.

Recommendation D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.

Recommendation D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.

Recommendation D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.

b) Privacy and Security

Finding D2c: Alaskans are concerned about the privacy of their personal health information. Progress has been made by the federal government to develop national health information security and privacy protection standards, and Alaskans have participated in these efforts, but more work remains to be done.

DRAFT UNDER DEVELOPMENT

Recommendation D2e: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska's statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange.

3. Telehealth/Telemedicine

Finding D3a: Alaskans have been particularly innovative in the use of telecommunications technologies as one way to bridge our vast geography and address health care access challenges.

Finding D3b: Barriers to adoption and use of telemedicine include:⁵

- Insufficient telecommunications connectivity in some rural Alaskan communities;
- Inadequate access to training for providers and their staff;
- Medical licensure restrictions across state borders;
- Misalignment of payment systems between costs and benefits.

DRAFT UNDER DEVELOPMENT

Recommendation D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.

Recommendation D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.

⁵ The order of the bullets in this finding is not meant to imply priority order of significance.

E. Access to Primary Care for Medicare Patients

Finding E(a): Alaska's Medicare-eligible population is growing.

Finding E(b): Medicare patients in some areas of Alaska experience trouble accessing primary care. The communities experiencing the most trouble with access are those with larger populations, notably Anchorage.

Finding E(c): One contributor to the Medicare access problem is an insufficient supply of primary care physicians willing to accept and retain Medicare patients in larger urban centers.

Finding E(d): Physicians report Medicare's burdensome administrative requirements, onerous audits, and what they find to be insufficient reimbursement rates as the primary reasons for limiting or denying provision of Medicare services.

Finding E(e): Care for Medicare patients is often more complex and time-intensive than for the general patient population.

Finding E(f): Mid-level practitioners are increasingly being used to solve the Medicare access problem.

Finding E(g): Medicare's physician reimbursement scheme is not rational and not reliable.

Finding E(h): Alaska physicians commonly report that Medicare's audit process designed to weed out fraud and abuse in the system focuses more on identification of billing errors than intentional fraud, incentivizes audit contractors to pursue and penalize providers for unintentional billing errors, and unnecessarily places an onerous administrative and legal burden on providers. The audit process, which appears to physicians to be based on an assumption of guilt, serves as a disincentive for Alaska providers to provide care for Medicare patients.

Background

Medicare is the federal government's health insurance program for the elderly (age 65 and older) and disabled. Created by Congress in 1965, it is partially funded with payroll taxes, and is administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health & Human Services. Medicare benefits include:

- **Part A (Hospital Insurance)**, covering inpatient hospital stays, some care in skilled nursing facilities, and hospice.
- **Part B (Medical Insurance)**, covering medically necessary services not covered under part A, such as outpatient hospital care, physician services, some preventive services, diagnostic tests, and durable medical equipment.
- **Part C (Medicare Advantage)**, an optional fee-for-service plan that provides Part A and Part B benefits through a private health insurance plan.
- **Part D (Medicare Prescription Drug Plan)**, provides prescription drug coverage.

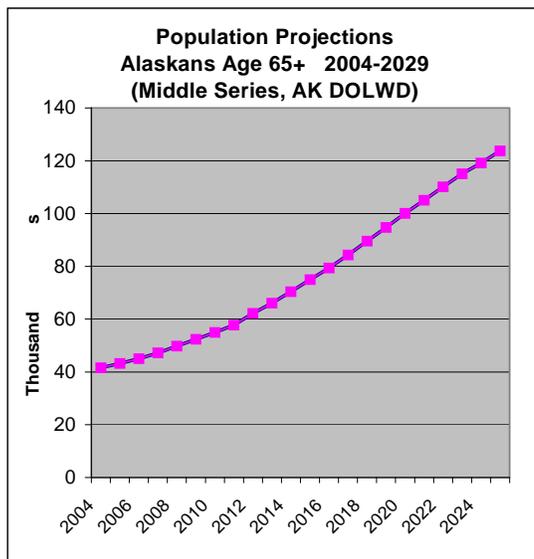
Medicare premiums are highly subsidized by the federal government, and spending for Medicare has grown steadily since its inception with costs doubling every four years between 1966 and 1980. Medicare costs, now at \$495 billion, accounted for 19% of all health care expenditures in the U.S. in

2009. One strategy the federal government implements to control soaring costs is limiting the physician payment rate.

The sustainable growth rate (SGR) formula for Medicare was created by Congress in 1997 to limit Medicare growth. The SGR, which is tied to the GDP, triggers reductions in the Medicare physician payment rate when costs rise too steeply – which has been the case each year since the SGR was created. Congress has not had the political will to enforce the reductions however, and has intervened each year to block them. While the statutory payment reductions have not been enforced, the SGR has had the effect of limiting potential payment rate increases. This strategy has not had the intended effect however, as reduced or limited payment rates are offset by increased utilization and total Medicare costs have continued to rise.

Another variable in Medicare physician rate setting are geographic differentials. Alaska has benefited from successful efforts by our congressional delegation to enact legislative provisions to boost the reimbursement rate for Alaskan physicians by increasing Alaska’s geographic differential. Effective January 2009 Alaska’s Medicare physician reimbursement rate was set permanently in federal law at 29% above the national average.

In 2008 there were 59,435 Alaskan Medicare beneficiaries, approximately 82% of whom were aged 65 or older with the remainder qualifying due to disability. The number of Alaskans aged 65 and older has more than doubled over the past two decades, from 22,095 in 1990 to 49,455 in 2008. That number is projected to nearly triple again by the year 2030 to 134,391.



The Problem

Many Alaskan Medicare beneficiaries, particularly those in more urban communities, report they have trouble finding a physician to take them as a patient. A study conducted by the Institute for Social and Economic Research (ISER) at UAA in 2008 confirmed there are few primary care physicians in Anchorage who will accept new Medicare patients.^{xliv} The researchers found that only 17% of Anchorage primary care physicians accept new Medicare patients compared to 61% nationally.^{xlv}

Driving this problem is the growing demand for Medicare services due to 1) the aging of Alaska's population, and 2) the need for increasingly complex care to treat and manage chronic conditions. As noted above, Alaska is experiencing significant growth in the Medicare eligible population that is expected to continue over the next two decades. The growing number of Medicare beneficiaries is compounded by the amount of extra time and effort it takes to treat a typical Medicare patient. One study found that for every 100 Medicare patients a primary care physician treats, that physician potentially has to interact with 99 other physicians in 53 different practices as they work to coordinate treatment of multiple and complicated health problems.^{xlvi}

The problem of growing demand is compounded by an inadequate supply of primary care physicians. Physicians report Medicare's low reimbursement rates, about one-third less than what private insurance pays in Alaska, as a primary reason behind decisions to not accept new Medicare patients or opt out of the Medicare system entirely. Other factors playing into these decisions include Medicare's burdensome administrative requirements, and a federal government audit process that is onerous and punitive. If there were more primary care physicians they might be able to spread the Medicare patient load and physician practices might more easily be able to absorb perceived losses from lower reimbursement and increased paperwork.

Potential Solutions

DRAFT UNDER DEVELOPMENT

Increase the supply of primary care providers

Support Clinics (limit to development of FQHCs)

Make payment scheme more rational

Address burdensome administrative and onerous audit requirements

One program the Commission considered as a potential solution to the Medicare access problem was PACE (Programs of All-Inclusive Care for the Elderly). PACE is a Medicare and Medicaid program that provides community-based care and services for older adults and people over 55 living with disabilities who would otherwise require nursing home level of care. PACE programs are required to provide a comprehensive set of wrap-around integrated medical and social services managed by an interdisciplinary team of health care professionals. Eligible Alaskans on Medicare choosing to participate in this optional program would be guaranteed access to primary care.

Initially started as a Medicare demonstration project in 1978, PACE proved so successful in improving outcomes for families and patients, health care providers, government and other payers, that it has been replicated in 31 states by 69 PACE organizations that serve nearly 18,000 individuals today. An evaluation by the federal government (then HCFA now CMS) conducted during the 1990s that studied the impacts of PACE on a wide variety of outcomes found that it resulted in long-lasting decreases in nurse visits to the home, inpatient hospital admissions, inpatient hospital days, and nursing home days. In addition, this study found that PACE enrollees lived longer and spent more days in the community than did non-PACE participants in a similar demographic control group.

The estimated number of Alaskans dually-eligible for both Medicare and Medicaid living in the Municipality of Anchorage is 7,539.^{xlvii} An estimated 10% may be eligible to participate in a PACE program. Two Anchorage health care organizations, Providence and Southcentral Foundation, have expressed some interest in potentially developing a PACE program in the community.

States may elect PACE as an optional Medicaid benefit through the Medicaid State Plan Amendment process. Approval of a State Plan Amendment by CMS does not obligate the state to implement a PACE program, but provides the option and positions the department and interested providers to move forward with program development.

Many of the potential Medicare enrollees in a PACE program probably already have access to higher level health care (negating somewhat the need for primary care), so implementing this program would most likely have a very small impact on the Medicare primary care access problem. Because only the frail elderly and disabled are eligible to participate in PACE, and those individuals generally already have access to higher levels of specialty care, the primary care access problem experienced by Alaskans in the general Medicare population probably is not a problem for those individuals. Having a PACE program in Alaska would most likely make only a very small impact on the Medicare access problem, but because of the many other benefits the Commission determined the state should in the direction of developing this program for Alaskans.

Recommendation E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by:

- Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved);
- Supporting development of a primary care internal medicine residency program;
- Supporting WWAMI program expansion but limiting state subsidy to those who return to AK to practice primary care and serve Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved); and
- Supporting mid-level practitioner development.

Recommendation E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.

Recommendation E(c): The Commission recommends that the Governor and Alaska Legislature support analysis of the cost of care in Alaska to determine appropriate recommendations to Alaska's congressional delegation related to federal policies needed to make Medicare's reimbursement scheme more rational and predictable.

Recommendation E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance

measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.

Recommendation E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.

Recommendation E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.

PART IV: Additional Issues & Potential Strategies for Future Analysis and Recommendations

A number of issues and potential strategies were identified by the Commission as important to a comprehensive approach to health care reform for Alaska. Those identified for future study are described briefly in this part of the report, and a suggested approach for planning related to these issues is provided in Part V.

A. Access to Health Care

1. Health Insurance Coverage

Because federal health care reform efforts underway during 2009 have focused primarily on increasing health insurance coverage, the Commission decided it would not be prudent to evaluate state options for expanding coverage until Congress completes their work.

Future study of access to health care coverage will require analysis and understanding of:

- **National reforms adopted in and for Alaska.** Strategies for increasing health insurance coverage in pending federal legislation include creation of a new government-administered insurance plan (“public option”), creation of health insurance exchanges, creation of non-profit member-operated health insurance cooperatives (“Co-ops”), expansion of Medicaid eligibility, individual and employer mandates requiring purchase of insurance, subsidies for low income individuals to purchase insurance, and insurance market reforms. If federal legislation passes, future state health commission work should include analyzing options and making recommendations for state policy direction needed to implement federal reforms at the state level. At a minimum, the work of this or a future commission to consider health insurance coverage expansion will require study of the impact of national reforms in Alaska.
- **Alaska’s private insurance market.** Only 23% of Alaskans have health insurance purchased on the private market. An additional 32% have insurance through their employers’ self-insured plan (exempt from state regulation under federal law (ERISA)). The remaining 45% of Alaskans have insurance through a public plan (Medicaid/Medicare), have health care provided by the military or the tribal health system, or are uninsured. Consideration of insurance market reform strategies will require study of the potential impact on Alaska’s health care system since less than a quarter of the population is covered by the state-regulated insurance market.^{xlviii}
- **The challenge small businesses face in obtaining insurance coverage for their employees.** Most of Alaska’s smallest businesses (those with fewer than 10 employees) cannot afford to offer health benefits to their employees. 52% of uninsured Alaskans are employed adults (9% are unemployed adults, and the remainder are children and others not in the work force). Those studying this issue in the future can benefit from the work conducted by the Department of Health & Social Services on health insurance coverage in Alaska during 2005-2007 under a grant from the Robert Wood Johnson Foundation. One of the findings from that study is the importance of understanding the seasonal nature of Alaska’s workforce. Other results from that study were obtained from surveys and focus groups conducted with Alaska business owners regarding their ability to obtain insurance for their employees and the barriers they face.

2. Health Care Workforce Development

Alaskans' access to quality health care is dependent on the availability of a well trained health care workforce with sufficient numbers of workers in the right occupations and the right locations to meet the needs of the population. The focus by the Commission during their first year on the physician workforce was just a first small step and only one component in what should be a comprehensive and sustained approach to development and implementation of a health care workforce strategy for Alaska. As noted in Part III, Section C of this report, there are numerous organizations collaborating on various aspects of health care workforce planning and development. Future study and improvement of Alaska's health care workforce cannot occur in isolation but must consider and build on these other efforts, and a comprehensive approach to addressing Alaska's health care workforce needs must include strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of health care workforce planning, development and support infrastructure

3. Behavioral Health & Long Term Care

The Commission noted that any effort to transform Alaska's health care system should consider the system from the consumer's perspective. From the individual health care consumer's perspective their behavioral health and long term care needs cannot be separated from their physical health needs. For that reason alone future health care planning and policy development efforts need to consider these other systems and services, but another important factor necessitating their inclusion is that behavioral health and long term care are significant cost drivers in the increasing cost of health care.

The Commission did not attempt in their first year to address issues related to the funding and delivery of behavioral health and long term care in Alaska. In part because there are other groups working on planning for behavioral health and long term care improvement, such as the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, and the Department of Health & Social Services, while there is no other entity charged with examining the broader health care delivery system. Future work must not leave these sectors out however. Recent plans, such as the Comprehensive Integrated Mental Health Plan and the State Plan for Long Term Care Services, should be reviewed.

If this or a future Commission wishes to foster innovation in transforming Alaska's health care system to better support a healthier Alaskan population they will need to coordinate with the behavioral health and long term care planning entities to ensure they are taking an integrated and holistic approach while not duplicating efforts.

B. Cost & Quality (Value)

The trend in state and federal health care reform efforts has been moving away from more simplistic cost control measures, such as caps on fees, towards a focus on improved value, thus most strategies to address the cost of care cannot be separated from strategies to improve quality.

1. Understanding the Cost of Care in Alaska

Information presented in Part II of this report indicates costs are higher in Alaska compared to other states, but a thorough understanding of the underlying reasons why costs vary is required prior to making specific policy recommendations to address the problem. Is it due to an insufficient supply of providers and insufficient competition between providers? Is there higher utilization of medical services in our state, and if so is it due to waste in the system or due to a higher prevalence of complex health conditions? How does fragmentation of the health care delivery system affect overall costs? Are payers unable or unwilling to negotiate the lowest possible price for services?

An important aspect of understanding variations in cost and underlying cost drivers is understanding how cost shifting occurs when one payer or set of payers underpays a health care provider (pays less than the costs the provider incurs to deliver the service). Prices charged are typically higher than the cost of care (and beyond profit margin) to make up for capped reimbursement by some providers, low fees negotiated with contract payers, and uncompensated care provided for uninsured and underinsured individuals who are not able to pay. Further analysis of cost drivers and cost shifting is needed to support development and implementation of successful strategies to control cost and improve value.

2. Primary Care Innovation

One of the Commission's central strategies for improving health care cost and quality is innovation in the patient care model at the primary care level. A lot of work must be done to implement the Commission's recommendation (#A2a) in support of primary care innovation. A collaborative effort with the primary care provider community and the Alaska Department of Health & Social Services needs to be undertaken to define the care model in more specificity beyond the identified characteristics, performance standards and measures must be developed, required internal organization supports for providers must be identified (such as information technology, knowledge management strategies for evidence-based practice, and development of effective teams), as well as requirements for a supportive payment and regulatory environment.

3. Value-Driven Purchasing

The fee-for-service approach to purchasing health care drives up the overall cost of care by incentivizing the provision of more services, and more costly services, while offering no incentives for improved quality or efficiency. "Value-driven purchasing" (VDP) identifies and implements purchasing practices intended to improve the value of health care services by holding providers accountable for both the quality and cost of services delivered to patients. VDP strategies include establishing standardized quality measures and reporting requirements, reporting of health care price and quality information, and use of direct incentives or disincentives to providers and consumers to promote improved quality of care and health outcomes as well as greater value for dollars spent. There are a number of strategies that could be studied to start Alaska on the road to value-driven purchasing.

a) Leverage State Purchasing Power

State government in Alaska represents a substantial payer for health care services. The state spent over \$1.5 billion last year in Medicaid expenditures, payment of state employee and retiree claims (not counting benefit credits paid to union health trusts), payment of state employee Workers' Compensation medical claims, and purchase of health care services for incarcerated offenders in the state correctional system. Collaboration between these state programs to develop shared value-driven purchasing strategies could provide significant market-share leverage for improving health care quality and cost in this state. This is an area that warrants additional study and potential recommendations.

b) Provider/Payer Cost Sharing Demonstration Projects

Because of the way the fee-for-service payment system is structured, health care providers may face situations where implementing measures that will reduce overall costs in the system and save money for the payer will actually increase the cost the provider incurs while reducing their revenue. This may be particularly true of hospitals, when investing in a costly new technology will improve patient outcomes and reduce hospital bed days. Future work on this issue could involve working with Alaska's hospitals to determine the extent to which these types of situations might delay innovation (and thereby delay improved patient outcomes and overall system costs), and consider the advisability of cost sharing demonstration projects.

c) Cost and Quality Transparency

Consumers need to know the price and quality of their health care options in order to make informed decisions and support their ability to participate more fully in their care. Empowering consumers with information not only supports improved decision-making on their part, but drives the entire system to provide better care for less money. An infrastructure to support transparency of health care cost and quality for Alaskan consumers, compiling and analyzing data on pricing and quality measures for physician services and hospital care and producing public information through an accessible and understandable reporting mechanism, does not currently exist.

Creating a system to provide transparency is not as simple as it may sound however. Pricing of individual services might be misleading without a more comprehensive picture of the total cost of care for a given condition and the expected outcomes of various care options. And transparency to support a market-based approach is not the only solution to the health care cost and quality problem. Health care is different than other goods and services, and all the conditions required for a competitive market do not exist in the health care market. Consumers do not fully control all of their health care dollars, and they cannot participate fully in all aspects of clinical decision-making about their care. In addition, many health care decisions are made for consumers in urgent or emergent situations when the consumer is severely ill, injured or under too much emotional stress to participate in their care decisions.

The potential benefits of and barriers to developing an information system to support consumer choice need to be fully understood as part of a strategic approach to making the system more transparent in order to improve quality and control costs.

d) Evidence-Based Medicine

The Dartmouth Atlas of Health Care^{xlix} and numerous other studies have consistently demonstrated wide variations in practice patterns and use of health care resources across geographic regions of the United States – the tests and treatment a patient with a given health condition receives varies based on the location in the country where the care is received. The waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending.

Moreover, research has documented those regions of the country where there is overuse of health care resources and resulting higher spending actually have lower quality of care and worse health outcomes.¹

ii iii

Decreasing the variability in health care services and spending requires the application of evidence-based medicine, which seeks to improve the decision-making of individual health care providers as they make diagnosis and treatment decisions about individual patients, to engage the patient in making informed decisions about their care, and to improve the policies of payers and health care delivery organizations. Evidence-based medicine is defined as a set of principles and methods intended to ensure that to the greatest extent possible, population-based policies and individual medical decisions are consistent with evidence of effectiveness and benefit.^{liii} The core idea behind evidence-based medicine is that the right care must be provided to the right patient in the right place at the right time and at the right price. And that all the determinations about what constitute these “right” decisions are based on the best available scientific evidence.

Improving evidence-based medical decision making may be the key to increasing value in health care – decreasing cost and increasing quality. There are a number of roles public policy can play in supporting and driving the use of evidence-based medicine. One state government example comes from Washington state, which has enacted a set of statutory provisions authorizing the state’s public payers (Medicaid, Workers’ Compensation, state government employee benefit plans, and the corrections department) to use evidence-based methods to improving quality of care, reduce wasteful use of health care resources, and determine what benefits should be covered.^{liv} Continuing work to improve value must include identification of the best approaches to expanding the application of evidence-based medicine in Alaska

e) Payment Reform^{lv}

The current fee-for-service payment system rewards health care providers for volume, not value. The financial incentives in this system lie entirely in the provision of more health care services and the sale of more health care commodities regardless of the quality of care provided, and may actually serve as a disincentive to creating health. Movement away from fee-for-service to new payment methodologies will require capacity for electronic information management, and therefore development and implementation of health information technology.

Reform of payment methodologies to reward quality can evolve in an incremental approach that can be initially pilot tested and gradually implemented to prevent harm to health care providers and their business interests, and in a way that supports providers as they transform the health care system over time. Research is required to guide implementation of new payment methods, and careful evaluation is required to assess cost-effectiveness, impact on quality of care and patient outcomes, and identification of unintended consequences. Following are three value-driven payment strategies this or a future Commission might choose to analyze and for which they might develop policy recommendations.

- ***Pay-for-Performance***

A pay-for-performance program provides a bonus payment for health care providers meeting certain standards of quality on a predetermined set of clinical measures. One approach would provide incentives for improvement over baseline performance as well. One challenge to developing a pay-for-performance program in Alaska will be the small size of many of Alaska’s hospitals and the lack of any large primary care group practices, as sufficient patient volume to provide statistically valid measurement of quality is required.

- ***Patient-Centered Primary Care Enhanced Service Payment***

The Commission in this report recommends the state of Alaska aggressively pursue development of innovative models of patient-centered primary care. Implementation of this recommendation will require further work to develop a detailed definition including the criteria a practice will have to meet in order to be deemed as meeting the new standard of care. The level and source of funding as well as the reimbursement mechanism for enhanced payment to support these new patient care models will need to be identified as well. As Medicaid is the state's largest payer, the Department of Health & Social Services is the logical entity to begin this next level of planning in support of the development of a Medicaid pilot program. DHSS might look to partner with other state agency health care purchasers and also private health insurance companies operating in Alaska to expand the reach of such a program.

- ***Bundled Payment Systems***

Payment bundling provides a global fee for a specified set of services. Development of this payment system could be evolved over time, starting with bundling of a limited set of hospital services related to certain acute care episodes (related to certain illness diagnoses for a specified period of time – for example, coronary artery bypass surgery and extending 30 days beyond discharge); and expanding over time to include physician inpatient care and post-acute care. A particular challenge to implementing this strategy in Alaska is the lack of integrated care networks here. Hospitals would initially have to contract with physicians and other service providers required to deliver the suite of services potentially needed to treat the bundled diagnoses or procedures. Other challenges involve the lack of sophistication of information and accounting systems of many of Alaska's smaller hospitals, the need to identify standards to ensure cost reduction does not negatively impact quality, mechanisms for avoiding "cherry-picking" of patients with the potential for fewer complications, and ways to reduce exposure to risk for providers.

f) Reporting and Non-Payment for "Never Events" and other Health Care Acquired Conditions

"Never events", as suggested by the term, are occurrences of medical errors that should never happen. The National Quality Forum maintains a list of 28 Serious Reportable Adverse Events considered "never events." Examples include surgery performed on the wrong body part, surgery performed on the wrong patient, leaving a foreign object in a surgical patient, patient death or disability due to use of a contaminated device, and patient death or disability due to a medication error.

CMS enacted a policy on July 31, 2008 to deny Medicare payment for medical services provided by a hospital for care required as the result of a never event. The new CMS policy also authorized State Medicaid Directors to enact this same policy in their state Medicaid program. A number of private insurance companies also have non-payment for never event policies.

Health care acquired infections, such as MRSA and C.Diff, are not included on the "never event" list; however the U.S. Centers for Disease Control and Prevention estimate that, in hospitals alone, these infections account for 1.7 million infections and result in 99,000 deaths annually. Many more are estimated to occur in other health care settings such as day-surgery clinics.

Required public reporting of these conditions can serve as an incentive for health care providers to increase efforts to prevent these problems, and also provide the public health system with information needed to assist health care providers with prevention techniques. Statutorily mandated health care acquired conditions reporting has been considered by the Alaska legislature in the past, and a plan for

developing a health care acquired conditions reporting system is currently under development by the Alaska Division of Public Health in the Department of Health & Social Services.

Future work on this issue could include an assessment of the incidence of medical errors in Alaska, the extent to which never event payment policies have been adopted in Alaska, and if there are opportunities for expanded and improved use of this policy as well as other strategies for reducing the occurrence of medical errors and improving patient safety.

5. Fraud & Abuse Control

The National Health Care Anti-Fraud Association, a public-private partnership of insurance company and government health care payers, estimates that a minimum of 3% of national health care expenditures is lost to fraud and abuse. Health care fraud - intentional misrepresentation or deception for the purpose of receiving higher reimbursement – can take many forms. One of the more common forms is for criminals to obtain patient information and pose as fictitious doctors, billing public and private insurance plans for service that was never rendered. The increased cost to payers for these fraudulent claims translates into increased premiums for private insurance holders and increased taxes to support Medicaid and Medicare.

It is difficult to determine the actual extent and impact of fraud and abuse in the health care sector – one cannot survey the criminals to determine how much they are making – but future work on this issue could include analysis of the current systems in place for fraud and abuse detection, investigation and prosecution for Alaska's Medicaid program and utilized by the insurance industry here. This analysis could include a look at current capacity, including funding and staffing levels, current practices, and also criminal penalties in state statute.

6. Tort Reform

Costs associated with medical liability (medical malpractice insurance premium costs, malpractice awards, and the practice of defensive medicine) are believed to be one driver of increasing health care costs, and reform of related civil justice laws has been one cost control strategy suggested in health care reform debates at the federal and at state levels. Estimates of potential savings from medical malpractice reform vary, but two very recent studies predict measurable savings. The Congressional Budget Office, in an October 2009 study for Senator Hatch, pegs the potential cost savings at 0.5% of total national health care spending. The National Bureau of Economic Research estimates, in a September 2009 study, that three different types of medical tort reform could reduce premiums for employer-sponsored health insurance plans by 1 to 2% each.

This is one strategy that has been addressed at least partially in Alaska. In 2005 the Alaska Legislature passed the Alaska Medical Injury Compensation Reform Act, limiting noneconomic damage awards for personal injury resulting from health care services to \$250,000 (limit increases to \$400,000 for wrongful death or injury resulting in permanent physical impairment that is more than 70% disabling). Alaska's court system also plays a role – discouraging frivolous lawsuits through Alaska Civil Rule 82, which requires the losing party to tort litigation to pay attorney fees and court costs to the prevailing party.

Future work related to this issue could include evaluation of the impact of the medical liability reform law passed in 2005 and study of additional strategies, such as regulation of medical malpractice insurance providers and development of programs to encourage alternatives to litigation.

C. Prevention

1. Public Health: Population-Based Health Promotion & Disease/Injury Prevention

Many diseases and injuries are preventable. Simple, non-medical, individual approaches to prevention such as hand washing, eating healthy foods, exercising, not smoking, drinking alcohol in moderation if at all, and wearing bicycle helmets and life jackets go a long way towards avoiding illness and injury. Individuals acting alone cannot create all of the conditions necessary to ensure good health however.^{lvi}

Since antiquity societal leaders recognized the importance of communal action to protect and promote the health of community members. Some of the rules described in the Old Testament were intended to prevent illness in the community from contaminated food or to prevent the spread of communicable disease. Today governments act to ensure safe food and water, maintain sanitation systems, provide vaccinations, deliver maternal and child health services, enact public policies such as seat belt laws, and operate programs such as tobacco control in order to optimize the health of the population under their jurisdiction.

Public health is defined as “what society does collectively to assure the conditions for people to be healthy.”^{lvii} There are two main characteristics of public health – 1) it is concerned with prevention rather than cure, and 2) it is concerned with population-level rather than individual-level health issues. Public health protects and improves communities by preventing epidemics and the spread of disease, promoting healthy lifestyles for children and families, protecting against hazards in homes, work sites, communities and the environment, assuring high quality health care services, and preparing for and responding to emergencies.

The significant improvements in health status in the United States during the 20th century – such as the increase in life expectancy from 45 years in 1900 to over 75 years in 2000 – are primarily due to public health interventions. Only five years of this 30 year increase in the average lifespan of Americans is attributable to the aggregate effects of improvements in medical care.^{lviii} 25 years of this gain are due to advances in public health.^{lix} Attainment of the Commission’s vision to transform Alaska’s health care system so it focuses on creating health and not simply treating illness and injury requires an understanding of and support for Alaska’s public health system.

A report by the Institute of Medicine published in 2002 found that the nation’s governmental public health infrastructure had been neglected, and an overhaul of its components (e.g., workforce, laboratories, public health law) was needed to ensure quality of services and optimal performance. Governmental public health agencies are the backbone of the public health system but do not work alone. Other organizations and sectors of society – including the health care delivery system, communities, business, the media, and academia are important partners in the public health system.^{lx}

In Alaska the state legislature is charged under the constitution to “provide for the promotion and protection of public health” (Constitution of the State of Alaska, Article VII, Section 4). The legislature has paid attention to the needs of Alaska’s public health infrastructure over the years. For example, by funding construction of two new technologically modern public health laboratories during the past 10 years, and by passing comprehensive reform of the state’s public health laws as they relate to public health functions (AS 18.15) in 2005. But a review of Alaska’s public health system has not been conducted in over a decade, and the capacity of the system to meet the need for population-based health promotion and disease and injury prevention is not well understood.

Future work by the Commission could include analyzing the adequacy of Alaska’s public health infrastructure, and developing policy recommendations to ensure the state’s public health system is sufficiently supported to deliver population-based disease and injury prevention and health promotion services.

2. Safe Water and Sanitation Systems

Safe water and waste water systems are essential to the prevention of disease. At the turn of the last century infectious diseases such as typhoid and cholera were the leading cause of death in the United States. Today many of those diseases have been virtually eliminated - in large part due to modern sanitation systems.

The association between safe drinking water and gastrointestinal illness has long been recognized, but a recent study conducted in Alaska by the CDC Arctic Investigation Program found a link between in-home water service and higher rates of respiratory and skin infections as well. The CDC team noted as “particularly disturbing” their finding that villages in one region with low in-home water service (less than 10% of homes served) experienced a respiratory infection hospitalization rate that was five-times higher than that of the general U.S. population, and a pneumonia hospitalization rate among infants that was 11-times higher.^{lxi} This study demonstrates the importance of having safe water that is not only available in the local community for drinking, but is also readily and easily available in the home for hygiene use.

Nearly every home in the U.S. – 99.4% according to the 2000 U.S. Census – now has running water and flush toilets. Alaska ranks last in the nation, with 93.7% of Alaska homes having these basic services. In rural Alaska however, only 77% of homes have modern sanitation facilities.^{lxii}

Support for improved sanitation systems in rural Alaska has been underway for some time, beginning with efforts of the Indian Health Service in the 1960s. In 1972 the state of Alaska enacted the Village Safe Water Act and began contributing state resources for construction of water projects. In 1994 the Rural and Native Sanitation Development Program, jointly funded by the state and federal government, was implemented. When this program began only 37% of rural Alaska households had adequate sanitation facilities. Today the Alaska Department of Environmental Conservation administers the Village Safe Water Program in partnership with the Alaska Native Tribal Health Consortium, providing state and federal funds totaling approximately \$60 million annually as well as technical assistance to Alaska’s smallest communities to design and construct water and wastewater systems.

Future work on the part of the Commission could include developing an understanding of the state’s plan for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community, and developing policy recommendations to ensure the state’s adherence to that plan.

3. Employee Health Risk Management

Health care spending on individuals with one chronic condition is more than twice that for people without such conditions, and spending is nearly 15 times greater on individuals with five chronic conditions. Employers and their insurance plans are increasingly working to change enrollees’ health behaviors as a means of achieving cost savings.

Health Risk Management Programs offer incentives such as lower premiums or contributions to HSAs for employees who agree to participate in the program. These programs generally require a health risk assessment and health improvement goals supported by lifestyle management tools, health coaches, and disease management plans.

Health Risk Management Programs have demonstrated effectiveness in reducing the rate of increase in health insurance premiums over time. The City and Borough of Juneau has a long standing program (since 1989), and over the years their premium rate increases have consistently been below the regional average. Safeway has flat-lined employee health benefit cost increases for four years straight since implementation of such a program. Providence Alaska, which is self-insured, launched a program in November of this year based on findings that the program will reduce costs.

While this strategy has primarily been about cost control, it demonstrates how a focus on prevention can work to make individual Alaskans healthier while achieving the added benefit of lowered costs.

PART V: 2010-2014 Strategic Plan for Transforming Alaska's Health Care System

A. 5-Year Planning Framework

The Commission's proposed five-year strategic planning framework is comprised of six essential elements:

I. Develop a Vision of Alaska's Transformed Health Care System

Accomplished in 2009 – Documented in Part I of this Report.

II. Accurately Describe Alaska's Current Health Care System

Begun in 2009 – Documented in Part II and Appendix A of this Report.

Next Steps:

1. Identify gaps in knowledge (e.g., why are prices for health care services higher in Alaska?)
2. Fill in the gaps and complete the picture
3. Analyze impact of national health care reform on Alaska

III. Build the Foundation for a Transformed Health Care System

- **Statewide Leadership**
- **Workforce Development**
- **Health Information Technology**

Begun in 2009 – Documented in Part III of this Report.

Next Steps:

1. Track implementation of 2009 recommendations
2. Implement 2009 recommendations requiring Commission action
3. Continue analysis and identification of solutions for further recommendations

IV. Design Elements Required for Transformation of Alaska's Health Care System

Begun in 2009 – Documented in Part III and IV of this Report.

Next Steps:

1. Continue working on design elements for primary care innovation and healthy lifestyles
2. Prioritize additional potential strategies (identified in Part IV) for analysis and recommendations

V. Measure Progress of Health Care Transformation

First Steps:

1. Work with system stakeholders to identify and develop consensus on indicators to measure progress (see potential indicator set below).
2. Develop data collection and analysis capacity for indicators that are not currently measurable.
3. Report progress on an annual basis to Governor, Legislature, and the general public.

VI. Communicate with the Public & Engage Stakeholders

Begun in 2009 – Commission Public Communication Plan included in Appendix D of this Report.

Next Steps: Implement Commission Public Communication Plan

Potential Health Care System Transformation Measures

1. Increase Access
 - Percent of Alaskans insured
 - Percent of Alaskans who have a specific source of on-going care
 - *Measure of insurance affordability*
 - *Indicator of workforce supply*
2. Control Costs
 - Annual growth rate in total health system expenditures in Alaska
 - Annual growth rate in Alaska's Medicaid expenditures
 - Impact on Alaska's state budget: new spending, net savings, new revenues
 - *Measure of provider revenues based on value*
3. Safe, High-Quality Care
 - Percent of population receiving key preventive services or screenings
 - Percent of Alaskans with chronic conditions controlled
 - Percent reduction in gap between benchmark and actual levels of quality
 - Percent reduction in gap between benchmark and actual levels of safety
4. Focus on Prevention
 - Percent of Alaskan communities with safe water and wastewater systems
 - Percent of Alaskans reporting health risks
 - Percent of Alaskans who smoke cigarettes
 - Percent of Alaskans who are obese
 - Percent of Alaskans who are binge drinkers
 - Percent of Alaskans with moderate to severe depression
 - Death rate among Alaskans due to injury (intentional and unintentional)

B. Suggested Action Plan for 2009 Recommendations **DRAFT UNDER DEVELOPMENT**

| Recommendation | Responsible Party and Action | Timeline and Resources |
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| <p>A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.</p> | <p>Governor: 2010 - Direct DHSS to investigate and develop recommendations for effective strategies to encourage and support healthy lifestyles of Alaskans. Legislature: 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.</p> | <p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs variable depending on availability of funding and approach to implementation</p> |
| <p>A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.</p> | <p>Commission: Include healthy lifestyles strategies analysis and recommendation development on 2010 work plan; Coordinate with DHSS investigation of same question.</p> | <p>Jan 2010 – Dec 2010 Cost: \$0 (assumes funding of Recommendation B2a)</p> |
| <p>A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.</p> | <p>Governor: Direct DHSS to: 1) collaborate with the AHCC to define patient-centric care models and identify performance standards and measures; 2) pursue grant opportunities to obtain funding for piloting medical home models of care; and, 3) identify statutory and regulatory barriers to development of such care models.</p> | <p>Jan 2010 – Dec 2014 Cost: \$0 (assumes funding of Recommendation B2a)</p> |
| <p>B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.</p> | <p>Governor: Direct DHSS to develop proposal for development health policy analysis capacity.</p> | <p>Jan 2010 – Dec 2014 Cost: Initial (2010) cost: \$0; Future costs to be determined</p> |
| <p>B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.</p> | <p>Legislature: Pass legislation to establish Commission in statute, and fund associated fiscal note.</p> | <p>Jan 2010 – Apr 2010 Cost: \$500,000 annual operating budget (based on DHSS fiscal notes for pending legislation)</p> |

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| <p>C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska’s health care reform and economic development agendas.</p> | <p>Governor: Direct state agencies to ensure health care and economic development plans include workforce needs and strategies. Legislature: Direct legislative committees to ensure health care and economic development agendas consider workforce needs and strategies.</p> | <p>Jan 2010 – Dec 2014 Cost: \$0</p> |
| <p>C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.</p> | <p>Governor: 2010 – Direct DEED, DHSS, and DoLWD to collaborate together and with stakeholders on the investigation and development of recommendations for strengthening the health workforce pipeline. Legislature: 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.</p> | <p>Jan 2010 – Dec 2014 Cost: \$0</p> |
| <p>C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska’s health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.</p> | | <p>Jan 2010 – Dec 2014 Cost: \$0</p> |
| <p>C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.</p> | <p>Governor: 2010 – Direct DHSS to collaborate with system stakeholders to develop a recommendation for the most appropriate entity to be charged with the responsibility for health care workforce development planning coordination.</p> | <p>Jan 2010 – Dec 2014 Cost: Estimated \$0 - \$250,000 depending on capacity and needs of designated entity</p> |
| <p>C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.</p> | <p>Commission: Include health workforce planning coordination, analysis, and recommendation development on 2010 work plan</p> | <p>Jan 2010 – Dec 2010 Cost: \$0 (assumes funding of Recommendation B2a)</p> |
| <p>C2a: The Commission recommends that the Governor and Alaska Legislature target the state’s limited financial resources invested in physician workforce development</p> | | <p>Jan 2010 – Dec 2014 Cost: \$0</p> |

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| to strengthening the supply of primary care physicians. | | |
| C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners. | Legislature: Pass legislation to establish educational loan repayment and financial incentive program to support recruitment and retention of primary care providers. Governor: Sign passed legislation into law | Jan 2010 – Apr 2010 Cost: Estimated \$1.5 - \$7.5M annually |
| C2c: The Commission recommends that the Governor and Alaska Legislature support an immediate increase in WWAMI seats from 20 to 24. Future expansion should be supported as resources allow. The WWAMI service requirement should be changed from 50% payback for not returning to practice in Alaska for 5 years, to 100% payback for not returning to practice as a primary care physician in Alaska for 5 years. | Legislature: Pass legislation to establish educational loan repayment and financial incentive program to support recruitment and retention of primary care providers. Governor: Sign passed legislation into law | Jan 2010 – Apr 2010 Cost: \$600,000 (estimated eventual annual cost once first expanded class is in its 4 th year) |
| C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine. | | |
| C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska’s congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas. | | |
| C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing “physician | | |

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| <p>extender” occupations as an additional approach to addressing the primary care physician shortage.</p> | | |
| <p>D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.</p> | | |
| <p>D1b: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska’s new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.</p> | <p>Commission: Include HIE, MMIS and ARRA EHR status review, analysis and recommendation development on 2010 work plan</p> <p>DHSS: Provide quarterly report to the AHCC on status of HIE, MMIS, and ARRA EHR implementation</p> | <p>Jan 2010 – Dec 2010</p> <p>Cost: \$0 (assumes funding of Recommendation B2a)</p> |
| <p>D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.</p> | | |
| <p>D2b: The Commission recommends that the Governor ensure Alaska’s statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.</p> | | |
| <p>D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public’s health. Alaska’s health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of</p> | | |

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| public health threats. | | |
| D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement. | | |
| D2e: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska’s statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange. | | |
| D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies. | | |
| D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies. | | |
| E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by: | | |

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| <ul style="list-style-type: none"> ○ Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved); ○ Supporting development of a primary care internal medicine residency program; ○ Supporting WWAMI program expansion but limiting state subsidy to those who return to AK to practice primary care and serve Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved); and ○ Supporting mid-level practitioner development. | | |
| <p>E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.</p> | | |
| <p>E(c): The Commission recommends that the Governor and Alaska Legislature support analysis of the cost of care in Alaska to determine appropriate recommendations to Alaska’s congressional delegation related to federal policies needed to make Medicare’s reimbursement scheme more rational and predictable.</p> | | |
| <p>E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska’s congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices</p> | | |

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| <p>than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.</p> | | |
| <p>E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.</p> | | |
| <p>E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.</p> | <p>Governor: Direct DHSS to develop and submit SPA to CMS adding PACE as an Alaska Medicaid benefit, and to develop capacity to negotiate rates with providers interested in developing a PACE program.</p> | <p>Jan 2010 – Dec 2010</p> <p>Cost: \$200,000 (estimated by DHSS; for actuarial consultant and Office of Rate Review staff)</p> |

C. 2010 Work Plan for the Alaska Health Care Commission

Following is a suggested approach to continuing the work of the Alaska Health Care Commission through 2010. This plan will need to be adapted and more details added based on the level of financial and staff resources allocated to this work once financing is determined.

- **Analyze Variations in Pricing and Resulting Cost Shifting in Alaska's Health Care Delivery System**
 - Contract with consultants who have expertise in health economics and health care business management.
- **Analyze Impact of National Health Care Reform** - If national reform legislation passes:
 - Identify state government roles and responsibilities for implementation
 - Analyze and determine potential impact on Alaska's health care system
 - Develop recommendations for Governor and Legislature for maximizing potential benefits and minimizing potential harms
- **Track Implementation of the Commission's 2009 Recommendations**
 - Monitor status of relevant bills during legislative session
 - Consult with Governor's Office on interest and approach to implementing recommendations requiring Governor's action
 - Commission staff to report quarterly to the Commission on status of implementation
- **Implement 2009 Recommendations Requiring Commission Action**
 - Recommendation A1b: Continue studying and develop additional recommendations to support healthy lifestyles
 - Recommendation A2a: Collaborate with DHSS and primary care provider community on definition of patient-centric care model and development of performance standards and measures.
 - Recommendation C1e:
 - Coordinate with the DHSS/AMHTA/UA Behavioral Health Workforce Partnership, Alaska Health Care Workforce Development Coalition and the Legacy Plan Health Care Workgroup
 - Continue analysis of health care workforce issues and develop additional recommendations
 - Recommendation D1b:
 - Coordinate with DHSS to receive a quarterly report on the development of the new statewide health information exchange, the new Medicaid Management Information System, and the use of ARRA funding for electronic health record deployment
 - Continue analysis of health information technology issues and strategies and develop additional recommendations
- **Prioritize, Analyze and Develop Recommendations on Potential Access, Value (Cost Containment and Quality Improvement), and Prevention Strategies described in Part IV of 2009 Report**
- **Implement the Commission's Public Communication Plan**
- **Develop an Evaluation Plan for Tracking the Performance of Alaska's Health Care System**
 - Work with health care system stakeholders to finalize performance metrics that will provide a snapshot of the efficiency, effectiveness, and safety of Alaska's health care delivery system.
 - Identify system for compiling, analyzing, and reporting performance metrics data.

End Notes

PART II

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