Report to Congress
of the Interagency Access to Health Care in Alaska Task Force

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Secretary of Health and Human Services
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Interagency Access to Health Care in Alaska Task Force

Report to Congress

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Executive Summary

In a country with great variability between states, Alaska deserves its reputation as being unique with its many distinct characteristics: its location apart from the contiguous 48 states, in an area with a climate often inhospitable to human habitation; vast distances between its own population centers; a population smaller than all but three other states, but with the largest Native population of any state (and the largest as a percentage of the total population); the largest military presence of any state; and citizens who share a spirit of self-reliance tempered by mutual interdependence.

The Affordable Care Act (Sec. 5104) mandated this report and established the Interagency Access to Health Care in Alaska Task Force to review how Federal agencies with responsibility for health care services in Alaska are meeting the needs of Alaskans and to report its findings and recommendations for consideration by the Congress. The participating agencies and nine members of the Task Force represent the Department of Health & Human Services (DHHS), the Centers for Medicare & Medicaid Services (CMS), the Indian Health Service (IHS), the Department of Defense (DoD) and its TRICARE Management Activity, the Secretary of the Army, Secretary of the Air Force, the Department of Veterans Affairs and its Veterans Health Administration (VA and VHA), and the Coast Guard (Department of Homeland Security).

Task Force members were appointed, and the Task Force conducted an initial preparatory meeting on July 16, 2010, followed by site visits throughout Alaska. The Task Force visited Soldotna, Fairbanks, Anchorage, Galena, and Nome. During this time, they visited community hospitals, the Bassett Community Army Hospital, the Air Force/VA hospital at Joint Base Elmendorf-Richardson, two tribally operated hospitals, Norton Sound Regional Hospital, the Alaska Native Medical Center, an Alaska Native Clinic operated by Tanana Chiefs Conference, Providence Medical Center Anchorage, and the Alaska Psychiatric Institute, and held meetings or listening sessions at each of these locations. In addition, members of the Task Force met with the Executive Director of the Alaska Health Commission, the Director of the Alaska Federal Healthcare Partnership, members of the Health Workforce Planning Coalition, and representatives of Alaska Native organizations. Also, certain members of the Task Force joined the VA in other site visits in Alaska during the same week.

In addition to conducting the site visits, the Task Force assembled and reviewed the findings of a collection of recent reports on health care in Alaska (see bibliography). The Task Force decided that it would seek to identify actions that federal agencies could take to promote solutions to problems that were identified. The Task Force's recommendations were specifically formulated to identify steps that Federal agencies could take to promote solutions to identified problems, and emphasize improving access to care in Alaska.

The findings and recommendations of the Task Force mirror in large part those of previous reports, but they focus on the part played by Federal agencies in providing health care to Alaskans. As such, they are best seen as describing some of the issues facing health care access in Alaska and, likewise, as part of the solution to improving health care access in the state as a whole. However, in addition to the unique features of Alaska mentioned above, Alaska has the

largest Federal presence in the provision of health care services for its citizens. As a practical matter, although Federal agencies are only part of the solution, in Alaska, they are significant contributors to expanding access and controlling costs.

Summary of Findings

Federal health agencies have made great strides in providing health care services to their beneficiaries under difficult circumstances. Many new facilities have been constructed since 1995, and a dedicated workforce has markedly enhanced services. There are, however, serious gaps in health care services in Alaska. Many of these gaps spring from Alaska's unique challenges due to its remoteness, small population base, and vast distances, which result in some of the highest costs for providing services in the U.S. Alaska does benefit from a number of special payment policies targeted at rural communities. The following summarizes the key findings resulting from the Task Force's efforts.

Regulatory Flexibility and Simplification

- Greater interagency collaboration may be necessary to ensure that overlapping policies are not unnecessarily inhibitive of health care access in Alaska. Agencies should consider opportunities to promote greater regulatory flexibility given Alaska's unique demographic and logistical circumstances.

Federal Reimbursement

- Physicians, non-physician practitioners, and others in the provider community have expressed dissatisfaction with Medicare, TRICARE, and VA reimbursement rates that they view as inadequate and unfair to Alaskan providers. Many in the provider community believe that a fair, adequate, and uniform Federal rate would alleviate existing provider shortages in Alaska.

Workforce and Training

- Rural Alaska has dramatic and severe problems relating to provider shortages and health care costs. Many rural areas also have social determinants of health that underscore the need for more robust and cost-effective health care delivery models.

- Workforce shortages exist in many areas, and there is consensus that some priority occupations and sub-specialties deserve immediate action, including primary care and psychiatric inpatient care.

- There is a shortage of primary care Medicare providers in Alaska, a problem most severe in Anchorage, but evident in Fairbanks as well as in rural Alaska.

- The Anchorage area has grown to the point where it now meets the threshold of size and resources necessary to sustain the higher level of care typically found in similar-sized cities.

- There is a need for an integrated state trauma care system and a second Level Two trauma care center in Anchorage, in addition to the existing Alaska Native Medical Center.

Health Information Technology

- There is a need for improvements in health information technology, building on a long history of innovation and practice that sets the IHS (and Alaska Native Tribal Health Consortium), VA, Department of Homeland Security (US Coast Guard) and DoD in Alaska apart as leaders in telemedicine. However, the interconnectivity necessary for coordination of care through electronic health information exchange is lacking. Historically, Federal agencies have not had coordinated mechanisms for paying for participation in integrated health information systems nor have they developed clear policies that will permit participation.

Participation in Formal Coordinating Organizations

- There are current longstanding and more recent examples of joint planning, coordination of services, and resource support for programs that can serve as vehicles for increasing capacity and capability, including the Alaska Federal Health Care Partnership and the Denali Commission, although both are constrained by available resources.

- Federal agencies are the largest payers for the state's medical transportation, including a somewhat uncoordinated emergency Medevac system as well as routine medical transportation, with Medicaid and Medicare paying over $100 million annually for transportation, the VA over $4 million, and DoD over $12 million. Medical transportation would benefit from more coordination among the Federal agencies.

- Although some of these gaps in health care services have been addressed with innovative thinking to produce programs and organizational structures fitting to unique Alaskan conditions, the report outlines additional steps to build on this progress.

Summary of Recommendations

The Task Force makes the following recommendations to improve communication, capacity, and capability in order to respond to the degree of difficulty presented by unique conditions in Alaska and to raise health care services in Alaska to meet a level that can be achieved in the rest of the nation.

Regulatory Flexibility and Simplification

- Each of the Federal agencies providing benefits, services, or both to Alaskans should, in collaboration with other agencies when necessary, conduct a regulatory review of policies that may inhibit interagency collaboration or access to benefits or services. Agencies should consider regulatory modifications that will grant enhanced flexibility to promote Alaskans' access to higher-quality, cost-effective, and better-coordinated health care. Examples include the DoD/VA's ability to develop Joint Incentive Fund (JIF) agreements, and possible

expansion of the concept to other Federal agencies. Another is the waiver flexibility of TRICARE for purchasing specialist care that is not available to other agencies.

Payment Reform and Flexibility

- Federal agencies providing health care reimbursement should support current projects to develop a budget-neutral, uniform provider reimbursement rate for similar services for Medicare, TRICARE, and the VHA.

- We applaud the CMS' development of a multi-payer medical home demonstration and encourage other Federal agencies to consider similar demonstrations.

- Federal agencies that reimburse for medical transportation should consider collaborating to develop unified policies and budget-neutral supplier rates in areas in Alaska where medical transportation is particularly limited or difficult. An update of the Federal Aviation Administration (FAA) survey may be needed to refine earlier recommendations.

- We support Indian Health Service funding increases as reflected in the FY 2011 President's budget request to reduce health disparities experienced by the American Indian and Alaska Native population. While funding for Indian Health Service has not always kept pace with inflation, in recent years Presidential Budget requests and Congressional Appropriations have budgeted for medical inflation.

- Federal payers that do not already do so should consider enhanced reimbursement rates for primary care providers furnishing services in shortage areas or who are representative of workforce shortage professions.

Workforce and Training

- The CMS is currently considering comments received for the regulation proposed on June 30, 2010 to reallocate Medicare-sponsored Graduate Medical Education residency slots as required in sections 5503 and 5506 of the Affordable Care Act. After the reallocation of these residency slots has occurred, Federal agencies sponsoring residencies in family medicine, internal medicine, pediatrics, and psychiatry should conduct an in-depth analysis of the adequacy of Alaska's workforce supply in these specialties and consider additional budget-neutral measures that would enhance and support physician and non-physician practitioner supply to Alaska.

- The Federal health agencies in Alaska are willing to coordinate with and promote other partners in the health care community to utilize their diverse clinical practices to support additional residencies in family medicine and the initiation of new residencies in internal medicine, pediatrics, and psychiatry.

- Federal agencies should look for opportunities to partner with existing training offerings rather than operating training programs that are exclusive to their own agency. Federal

agencies should also seek out training at the University of Alaska or other educational offerings in the state rather than develop their own training programs in every case.

- Additional opportunities to improve the availability of providers should be explored, including the development of reciprocity agreements with states in the Pacific Northwest to allow providers licensed in those states to practice in Alaska and to expedite the process of granting Alaska licenses to medical professionals.

- The DoD and VA have a Memorandum of Understanding in development for a single credentialing process that allows a provider to work in either DoD or VA facilities. Once signed, they should implement it as quickly as possible.

- Federal agencies should analyze the merits and feasibility of adapting the successful Federal-private partnerships in San Antonio and Tacoma to support the development of an integrated state trauma care system, including additional Level II trauma centers.

Health Information Technology

- Federal agencies should coordinate efforts to promote adoption of interoperability between the electronic health records (EHRs) of DoD, VA, and the IHS, perhaps as a demonstration project.

- The agencies represented on the Task Force, the Denali Commission, the Federal Communications Commission, the United States Department of Agriculture, and the Health Resources and Services Administration (HRSA) should coordinate efforts to streamline and combine grant opportunities, where possible, to expand broadband access throughout the state.

Participation in Formal Coordinating Organizations

- Expand opportunities for Federal health agencies to collaborate with the State of Alaska Health Commission.

- Expand Alaska Federal Health Care Partnership to include other agencies of the Department of Health & Human Services (DHHS) to foster greater coordination with enhanced accountability and transparency.

Outreach

- All Federal agencies that provide health benefits, coverage, and/or services should coordinate outreach, enrollment, and benefits counseling to the extent practicable. Federal agencies should also cross-reference partner Federal agencies in their printed and website materials.

- Federal agencies should analyze the merits of adapting existing web portals to create a single portal for use by U.S. citizens to determine eligibility for medical benefits.

Endorsements

In addition to the Task Force recommendations, we also lend our support to recommendations from other groups that have analyzed access to health care in Alaska with the following endorsements:

- Conducting a feasibility study for the establishment of a Medical School in Alaska.

- Increasing the number of the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) slots for training primary care physicians.

- Continuing FAA efforts to improve aviation infrastructure in Alaska to enable medical evacuation flights to communities that lack other means of accessing appropriate healthcare.

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Introduction

In a country with great variability between states, Alaska deserves its reputation as being unique: its location apart from the contiguous 48 states, in an area with a climate often inhospitable to human habitation; vast distances between its own population centers; a population smaller than all but three other states, but with one of the largest indigenous (Alaska Native) population of any state (and the largest as a percentage of the total population); the largest military presence of any state; and citizens who share a spirit of self-reliance tempered by mutual interdependence.

Section 5104 amended by section 10501 of the Affordable Care Act mandated this report and established the Interagency Access to Health Care in Alaska Task Force to review how Federal agencies with responsibility for health care services in Alaska are meeting the needs of Alaskans and to report its findings and recommendations for consideration by the Congress. The participating agencies and nine members of the Task Force represent the Department of Health & Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), the Indian Health Service (IHS), the Department of Defense (DoD) and its TRICARE Management Activity, the Secretary of the Army, Secretary of the Air Force, the Department of Veterans Affairs (VA) and its Veterans Health Administration (VHA), and the Coast Guard (Department of Homeland Security).

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In addition to conducting the site visits, the Task Force assembled and reviewed the findings of a collection of recent reports on health care in Alaska (see bibliography). The Task Force decided that it would seek to identify actions that Federal agencies could take to promote solutions to problems that were identified. The Task Force's recommendations were specifically formulated to identify steps that Federal agencies could take to promote solutions to identified problems and emphasize improving access to care in Alaska.

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Alaskans. As such, they are best seen as describing some of the issues facing health care access in Alaska and, likewise, as part of the solution to improving health care access in the state as a whole. However, in addition to the unique features of Alaska mentioned above, Alaska has the largest Federal presence in the provision of health care services for its citizens. As a practical matter, although Federal agencies are only part of the solution, in Alaska they are significant contributors to expanding access and controlling costs.

Organization of the Report

The report is organized in twelve sections. The introduction is followed by a description of Alaska's geography, climate, and population. The third section presents a brief narrative of the health status of the state's citizens. In the fourth section, the Federal responsibility for health care services is described, followed by a brief (fifth) section that describes the Alaska Federal Health Care Partnership. The sixth and seventh sections of the report discuss the barriers to improving care presented by the high cost of living in Alaska and health care workforce scarcity. In the eighth section, a closer review of the Medicare primary care provider shortage is presented, including some proposed solutions to the problem. The ninth section on health care technology documents some interesting advances in the state and some particularly Alaskan challenges to fully realizing the benefits of advanced health care technology. The tenth section lists the Task Force findings, and the eleventh shares the Task Force recommendations. A brief conclusion summarizes what the Task Force learned in Alaska and how it informed the Task Force recommendations.

Demographics

Alaska is the largest state in the union, with 586,412 square miles of territory. It is more than 2.5 times the size of Texas, the next largest state. Its north-south dimension is 1,420 miles and east-west is 2,400 miles. In contrast to its large geographic size, Alaska's small, nearly 700,000-person population makes it the fourth least populous state, with only North Dakota, Vermont, and Wyoming having fewer residents. In spite of its low population density of 1.1 persons per square mile, Alaska's population in 2000 was 65.6% urban. The Census definition of "urban" changed in 2000, from places of 2,500 or more to a density measure. By the old 1990 definition, Alaska was 73.9% urban in 2000. [1]

To describe the geopolitical areas, Alaskans use a combination of boroughs (16) and census areas (11), defining 27 total areas. Overall, Alaska has either whole or partial medically underserved area/population (MUA/P) or governor-designated medically underserved population (MUP) status in 23 of the 27 boroughs and Census areas. According to the Alaska Center for Rural Health, there is a total underserved population of 370,088 across the state, representing 59% of total residents. This reflects Alaska's low population density and extreme rural nature.

While over half of the state's population is located in the Anchorage and nearby Matanuska-Susitna Boroughs, most of the state's Alaska Native population is rural, and most of the state's rural areas are majority Native. In fact over 75% of the population of the state's five most rural western and northern boroughs is Native.[2] Rural health has a decidedly Native influence and, in response, the Alaska Native Health System is built to respond to this unique population located in the most rural areas of the state. Since Alaska Native clinics often provide the only health care in a village, issues impacting these clinics have implications for many rural residents.

Table 1 below shows the Alaska Native population within the context of the state's entire population. It includes 11 of the State's 27 areas that represent 87% of the state's population and 80% of the state's Native population. The Alaska Native population of 121,929 represents 18% of the state's total population, a statistic which has substantial implications for the delivery of health care, the need for cultural sensitivity in the delivery of care, and the role of translation services. Most of the state's non-Native population lives in urban settings like Fairbanks, Juneau, and Metropolitan Anchorage or the Kenai Peninsula. In most cases, access to health care is less problematic in these boroughs. The state's public health nurse system has adapted its mission based on these demographic characteristics. It has reached out to many rural areas and sought to capitalize on the Indian Health Service Electronic Health Record (RPMS) by using it as its primary patient database.

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[1] "Alaska Population Overview • 2001-2002 Estimates," Department of Labor and Workforce Development, 2002.
[2] "Anchorage Migration", J. Gregory Williams, *Alaska Economic Trends*, February, 2010.

Table 1. Alaska Population

2008 estimates	Total Pop	Ranked by # Native	% Native	% of Total state Natives Pop.
Alaska	679,720	121,929	17.90%	Alaska
Anchorage Municipality	284,994	31,539	11.10%	25.90%
Bethel Census Area	**16,940**	**13,984**	**82.60%**	**11.50%**
Fairbanks North Star Borough	89,896	9,534	10.60%	7.80%
Matanuska-Susitna Borough	82,515	7,704	9.30%	6.30%
Nome Census Area	**9,499**	**7,138**	**75.10%**	**5.90%**
Wade Hampton Census Area	**7,670**	**6,909**	**90.10%**	**5.70%**
Northwest Arctic Borough	**7,407**	**5,922**	**80.00%**	**4.90%**
Kenai Peninsula Borough	52,990	5,293	10.00%	4.30%
Juneau Borough	30,427	4,720	15.50%	3.90%
North Slope Borough	**6,706**	**4,690**	**69.90%**	**3.80%**
Sum of above Boroughs	589,044	97,443		80%

Also significant is Alaska's younger population. Both the Native and non-Native population pyramids reflect a decidedly younger population than the nation. Although the senior population is expected to grow rapidly (discussed elsewhere in this report), the number and percentage of the population over 65 will remain much lower than the rest of the nation for the foreseeable future.

A full socioeconomic description of the state is beyond the scope of this report, but even a brief review demonstrates wide variations between the Native and non-Native population in the state. Alaska's non-Native population has a household income higher than the nation as a whole, while the Native population is far below both the state and national average. 18.7% of Natives over 18 are below the poverty level compared to just 6% of Alaska non-Natives. Educational achievement has a similar gap, with 37.1% of the state's non-Native population attaining an associate's degree or higher, compared to only 9.4% of the Native population.[3]

While the state currently enjoys a lower-than-average unemployment rate, that rate is higher than the state's long-term rate. As of July 2010, many of the rural boroughs of Alaska had unemployment rates that were nearly double the state rate of 7.9%. Another factor that complicates health insurance coverage in the state is the large seasonal jobs component of total state employment. Many citizens do not have year-round employment, and the transition between receiving insurance coverage through their employer and being covered by public insurance often leaves them uninsured.

[3] Alaska Native Health Status Report. Alaska Native Epidemiology Center, Alaska Native Tribal Health Consortium, August 2009 pp. 9-19.

The demographic determinants of health play a strong role in health status in any state, but Alaska presents some severe challenges that are recognized by both state and tribal governments in Alaska. The state has responded with programs that serve the largely Native rural population, and tribes have responded by building an Alaska Native Health System based in local villages, with referral hubs and, where necessary, referral to Anchorage health centers. Likewise Federal agencies have responded. The Alaska VA Healthcare System (AVAHS) provides a variety of outreach efforts throughout the state of Alaska. The Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Team routinely visits the Warrior Transition Units located in Fairbanks and Anchorage and attends the National Guard's Post Deployment Health Re-Assessment (PDHRA) events. These AVAHS outreach activities involve education of members on how to access a variety of VA benefits. Recently AVAHS has organized a "Focus on Veteran" series that is teleconferenced statewide through the Alaska Native Federal Access Network that connects village health clinics and corporations statewide. To date, participants have been from Kotzebue, Unalaska, Kodiak, and Metlakatla, which are representative of communities from all the geographic areas of Alaska.

Health Status of Alaskan Residents

The overall health status of Alaskans does not vary greatly from all Americans when one considers its younger age demographic. Alaskans annually report that they are in good or excellent health at a higher rate than the national average. The non-Native all-causes death rate is similar to the national average.[4] There are significant differences, however. The 2005 life expectancy of 78.5 years is slightly more than the U.S. rate of 75.0. The health status of Alaskans is, however, characterized by high rates of unintentional causes of deaths (violent deaths due to injuries and homicide), rates of tobacco and alcohol use that are higher than the national average, a relatively high incidence of infectious diseases, and dramatic disparities in health between Alaska Natives and other Alaskans.

Nonetheless, Alaska does well on some traditional measures of health status. Alaska consistently has one of the lowest rates of low-birth-weight deliveries in the nation as well as an infant mortality rate and teen birth rate lower than the national rate. Mortality due to coronary heart disease is also lower than the U.S. rate. It is important to keep in mind Alaska's unique demographics when comparing health status of Alaskans to those in other states. With its younger population and large Alaska Native population, the averages may conceal more than they explain.

Direct comparisons between Alaska Natives and non-Natives highlight troubling differences.[5] For example, a 2009 report showed that significantly more non-Natives than Alaska Natives rated their health as very good or excellent.[6] One uncommon difference between the two groups is that non-Natives have a higher rate of diabetes than Natives, the reverse of the pattern in every other state with sizable AI/AN populations.[7] However, the rate of the increase in the prevalence of diabetes among Alaska Natives is among the highest in the nation, for example, exceeding 200% between 1997 and 2007 in Norton Sound and Bristol Bay.[8] Some of the risk factors for poor health highlight lifestyle differences as well. For example, Alaska Natives are twice as likely to be current smokers (41%). Although Alaskans are less likely to report inactivity than the national average, obesity has increased by 64% for Alaska Natives from 1991-1992 figures.

There have been vast improvements over the past 30 years in the health of Alaskans, including Alaska Natives. Much of the improvement is in public health, with sanitation and clean drinking water being the most notable. However, there still remain over 100 villages without adequate drinking water and sanitation despite decades of leadership from the IHS (now provided through a tribal self-governance compact with the Alaska Native Tribal Health Consortium) and other state and Federal partners, and over a decade of service from the Denali Commission.

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[4] *Alaska Behavioral Risk Factor Survey, 2008 Annual Report*. Alaska Division of Public Health.
[5] *Alaska Native Health Status Report.* Alaska Native Epidemiology Center, Alaska Native Tribal Health Consortium, 2009.
[6] Behavioral Risk Factor Surveillance Survey BRFSS, State of Alaska Department of Health and Social Services, Alaska 2008.
[7] Alaska Native Health Programs have 10 years experience in improving screening, detection and prevention activities through the Special Diabetes Fund for Indians (SDPI).
[8] *Alaska Native Health Status Report.* Alaska Native Epidemiology Center, Alaska Native Tribal Health Consortium, 2009.

Although heart disease is the second leading cause of death for Alaska Native people, the Alaska Native heart disease death rate decreased by 43% between 1980 and 2007. Infant mortality is down by 50% for both groups since 1980 through 1983, but the Native rate is still double that of non-Natives. Mental health service is the second most common service offered after respiratory illness services at Alaska Native outpatient clinics.

Suicide has also received special attention in Alaska. Suicide is the 4th leading cause of death for Alaska Native people and the 10th leading cause of death for non-Natives. The suicide rate for Alaskan men is about 3 times that of women. Men aged 20-29 years had the highest suicide rate of any age group, male or female. During 2004-2007, the Alaska Native suicide death rate was 3.6 times greater than for U.S. non-Natives and 2.5 times greater than for Alaska non-Natives.

The state and the Alaska Native Health System have addressed the suicide issue with grant-funded programs as well as behavioral health programming. Unfortunately, as discussed elsewhere in this report, shortages across every level of the system leave large gaps in providers and programs.

It is clear from even a brief review of Alaskans' health status that efforts to address Alaska's unique circumstances are required, so that a targeted effort to improve health status can achieve the goal of improved health for the state's citizens.

Federal Responsibility for Health Care Services in Alaska

Federal health programs are the leading provider of health care services to Alaska citizens. The Federal government spent an estimated $1.5 billion for health care services in Alaska in 2006, constituting approximately 31% of total health care expenditures in the state.[9]

The Federal responsibility for health care in Alaska includes the requirement to provide health care for 138,000 users of the Indian health system; 125,000 residents enrolled in Medicaid; 64,000 elderly and people with disabilities enrolled in Medicare; about 75,000 receiving military medical coverage as active service personnel, military families, or military retirees; and about 15,000 patients of the VHA. Since 40,000 AI/ANs are dually eligible for IHS-paid services and Medicaid, and another 9,500 also eligible for Medicare, the total number of Federal beneficiaries is less than the total of all these categories. The Federal government also provides funding for the rapidly growing network of Community Health Centers in Alaska, which provides care for over 80,000 Alaskans.

Since many Alaskans are eligible for employer-paid health insurance, pay for their own insurance, or receive some services as well as insurance coverage from more than one of the above payers, it is not easy to characterize in precise numbers enrollment, payment, or health coverage responsibilities for health care services in Alaska. It is likely, however, that slightly over 50% of the state's residents receive health care paid primarily by the Federal government.

Therefore, the Federal government has a significant responsibility for the provision of health care services in Alaska. The state ranks first in the nation in two categories, with 18% of the population receiving IHS-paid services and about 14% receiving military (TRICARE) or VHA paid services. When comparing these numbers to national numbers of less than 2% accessing tribal health programs and about 4% accessing military/VA health programs, it is easy to see that the Federal government has a far greater responsibility in Alaska's health care system than any other state, so it is critical to understand the Federal role for anyone wanting to understand the Alaska health care system.

In addition, although Medicare enrollment is less than the national average, Medicaid's enrollment exceeds the national average. With health care reform's planned expansion of Medicaid in 2014 predicted to add as many as 50,000 beneficiaries in Alaska, it is all the more necessary to accurately understand the role of the Federal government in the provision of health care services in the state.

Centers for Medicare & Medicaid Services

Medicaid

In 2008, there were 125,138 enrollees in Alaska Medicaid. 48,342 were American Indians or Alaska Natives, equaling 38.6% of total Medicaid enrollees. Overall state and federal Medicaid expenditures totaled about $1 billion in 2008, with 2010 spending estimated to be in excess of $1.2 billion, with $708 million in Federal funds and $481 million in state funds. Alaska received

[9] 2009 Biennial Report, Alaska Federal Health Care Partnership: Advancing Health Care, p. 7.

an enhanced Federal Medical Assistance Percentage (FMAP) rate of 62% for most Medicaid services from the American Recovery and Reinvestment Act, higher than the state's typical 50-52%. In addition, 17% of total spending is reimbursed at 100% Federal match for services provided in IHS-funded facilities in the Alaska Native Health System. In other words, the state of Alaska saves about $90 million a year in the State share of Medicaid expenditures due to the provision of services for residents treated in the facilities of the Alaska Native Health System.

Medicare

The CMS reports that as of December 2009 there were 63,584 beneficiaries of Medicare in Alaska (about 9% of the population). About 1 in 6 of this total are AI/ANs (9,581 in 2006).[10] The Native population experiences more Medicare-paid disability enrollment than the general population, but less end-stage renal disease program enrollment than other parts of the IHS health system. The Medicare population is an important area of population growth and future health care expenditures in the state as its population ages.

Military Health System

The Military Health System in Alaska is complex, with direct care provision for beneficiaries including active duty, active duty family members, and retirees and retiree family members through Military Treatment Facilities (MTFs). The purchased care system provides care to eligible beneficiaries when the capability and/or capacity do not exist in the direct care system. The Task Force included each component of this system and visited two VA clinics, one U.S. Air Force hospital, and one U.S. Army Hospital. The mission of the system is to have combat-ready troops with special attention to deployed forces and returning warriors. The system pays special attention to surge capacity necessary to support deployments and disaster response, and also to support returning troops and combat casualties. Alaska is not currently a primary location for returning wounded, but some contingency planning is underway for a possible expanded role if European air routes are interrupted (as they were due to Iceland's volcanic eruptions in 2010).

The TRICARE program provides health care for the military's uniformed personnel and retirees, and for their dependents and survivors—the more than 9.6 million people eligible world-wide to use its integrated system of military health care facilities and providers, and regional networks of contracted civilian providers. In Alaska, 89,288 people are eligible for TRICARE services (13% of the state's population). In 2009, the DoD costs for that medical care enterprise-wide was $44.8 billion. TRICARE has three regions, and Alaska is in the West region.

TRICARE has a separate Alaska chapter in the TRICARE Operations Manual, and the system is unique when compared to other regions of the U.S. Accommodations have been made to ensure that there are participating providers for TRICARE beneficiaries. By statute TRICARE reimbursement rates must, to the extent practicable, be set in accordance with the same

[10] *American Indian and Alaska Native Medicaid Program and Policy Data California Rural Indian Health Board March 2010,* James Crouch, Chi Kao, Juan Korenbrot, Carol Korenbrot, page 74, Table B.6

reimbursement rules as apply to payments for similar services by Medicare. However, TRICARE can make certain exceptions to this.

In Alaska, TRICARE has used its demonstration authority to evaluate the effects of setting its reimbursement rates 40 percent higher than Medicare rates. This demonstration will expire on December 31st, 2012. These revisions coupled with the ability to use Locality Based Waivers[11] authorized by the 32 Code of Federal Register (CFR) 199.14, have resulted in a positive change in provider acceptance for treating TRICARE beneficiaries. In 2007, approximately 465 providers in Alaska were treating TRICARE beneficiaries. Today, 814 providers are treating TRICARE beneficiaries, a 75% increase, opening up access to local specialty care and decreasing costs of health care due to reduction in travel costs associated with beneficiaries needing to travel out of state for care.

United States Air Force

The 673d Medical Group is a DoD/VA Joint Venture medical facility located in Anchorage at the Elmendorf Air Force base (Joint Base Elmendorf Richardson) with 60 inpatient beds. The hospital offers a wide range of services with many specialties. It also offers a Multi-Service Unit, an Ambulatory Procedure Unit, Labor and Delivery, and a fully functioning Intensive Care Unit. In addition to serving the Air Force and VA, the facility is the Army Hospital for southern Alaska, as well as the Coast Guard hospital. Similarly, north of the Alaska Range, the Army's Bassett Army Community Hospital serves the medical needs of the 654 Medical Group at Eielson Air Force Base near Fairbanks.

The Air Force has invested substantial growth in staff to support the recent increases in Army families assigned to bases in Alaska. A 34,000 square foot addition to the hospital will provide additional space for mental health, traumatic brain injury, public health, and other clinical services. In addition, in 2009, the Secretary of the Air Force accepted a proffer from the Fisher House Foundation to build a 20-suite Fisher House on the medical campus at Joint Base Elmendorf-Richardson, which will provide high-quality, no-cost lodging options for families of DoD, USCG, and VA patients receiving care at the 673 MDG DoD-VA Joint Venture hospital. The Alaska Guard and the Air Force recently partnered to construct a medical training facility on the campus, which will support Army and Air Force Guard medical needs, with support from the 673 Medical Group. The Joint Venture Hospital also supports numerous existing medical training programs, ranging from the local family practice residency and nursing school to pharmacy doctorate programs located in the Lower 48.

United States Army

The Bassett Army Community Hospital is a 32-bed inpatient facility that opened in 2007, replacing a 200-bed facility. Approximately 25,000 Alaskans received inpatient and outpatient care at the hospital in 2009. The hospital serves military personnel at Fort Wainwright, Fort Greely, Eielson Air Force Base, and remote military sites north of the Alaska Range, plus military

[11] TRICARE has statutory authority to grant locality-based waivers to except from conformance with Medicare rates. In this regard, TRICARE currently has a number of area and specialty-specific locality-based waivers in effect.

dependents and retirees. The hospital provides space and ancillary health services to the onsite VA Community Based Outpatient Clinic. The Army is building a new 200-bed Warrior Transition Unit on the medical campus at Joint Base Elmendorf-Richardson to enable one-stop care to the greatest extent possible for wounded and ill soldiers.

United States Coast Guard

The Coast Guard depends heavily on the services provided by the Army and Air Force MTFs and the purchased care system of TRICARE. 2,236 Alaskans are eligible for Coast Guard health care services, and 1,902 received care in 2009. The largest clinic is located in Juneau and will re-open as a joint VA Coast Guard clinic this year. Other clinics are located at Kodiak, Sitka, and Ketchikan. The Coast Guard relies on the other components of the Military Health System for health care services and has established several joint agreements for the provision of care.

Alaska Native Health System

The Alaska Area IHS, in collaboration with Alaska Native tribes and tribal organizations, provided health services to 138,298 Alaska Natives in 2009. Approximately 99% of the Alaska Area IHS budget is managed by tribes and tribal organizations under Title I and Title V of the Indian Self-Determination and Education Assistance Act (P.L. 93-638, as amended). The IHS provides $502 million (FY 2009) for the health care needs of the states' 122,000 American Indians and Alaska Natives (AI/AN), the vast majority of whom are Alaska Natives. The IHS user population is 138,000 and the difference between this number and the Census count is due to the difference in the definitions used to estimate population versus the actual count of active users of the IHS health care programs by eligible AI/ANs. $383 million of these funds are for health care services (with an additional $90 million for contract support costs) and the balance ($29.9 million) is for facilities expenditures including sanitation, drinking water, new facilities construction, maintenance, and improvement.

IHS-funded, tribally managed hospitals are located in Anchorage, Barrow, Bethel, Dillingham, Kotzebue, Nome, and Sitka, Alaska. There are 36 tribal health centers, 166 tribal Community Health Aide clinics, and five residential substance abuse treatment centers. The Alaska Native Medical Center in Anchorage is the state-wide referral center and gatekeeper for specialty care. State-wide health promotion and disease prevention programs are operated by the Alaska Native Tribal Health Consortium, which is managed by representatives from all of Alaska's Tribes.

In addition to the IHS funding, Medicaid paid $280 million for 27,737 Alaska Natives who received Medicaid-paid services through the Alaska Native Health System in 2004, the last year that these totals are available. $94.2 million was paid directly to the tribally operated programs and another $185 million to non-tribal health care providers. Medicaid grew rapidly in the early years of the decade before leveling off during the last 5 years. Close attention to these two programs and their possible growth or contraction is essential for those dependent on this system of health care service provision.

Department of Veterans Affairs: The Alaska VA Healthcare System (AVAHS)

There are 76,400 veterans living in Alaska. 15,000 of 26,708 VA-enrolled veterans received health care services from the AVAHS in FY 2009. The AVAHS provides outpatient care directly in four clinics in Anchorage, Fairbanks, Kenai, and Wasilla, with another scheduled to open this year in the Federal building in Juneau. Inpatient care is provided at the VA/DoD Joint Venture hospital located on Elmendorf Air Force Base in Anchorage and through a contract with Providence Alaska Medical Center in Anchorage, as well as purchased care with hospitals in outlying communities. Like the Military Health System described previously, the VA's purchased care system provides care to eligible beneficiaries when the capability and/or capacity do not exist in the direct care system.

The new VA Community Based Outpatient Clinic (CBOC) in Anchorage is connected to the 673rd Medical Group Hospital by a secure, enclosed access point, while access to the VA clinic is outside the USAF Security checkpoint. There is also an Inter-Service Sharing Agreement with Bassett Army Community Hospital at Fort Wainwright in Fairbanks and that clinic is located within the hospital and within the security gates of the base. Finally, tertiary inpatient care is provided at the nearest VA facility, typically the VA Puget Sound Health Care System (VAPSHCS) in Seattle, WA. If these facilities are unable to provide needed services or if the service need is urgent or emergent, care is purchased in the community.

The AVAHS also purchases care from other providers in the community. The VHA has immediate plans to conduct a study to develop an actuarially-based reimbursement rate for providers, including a review of the feasibility of a uniform rate inclusive of VHA, Medicare, and TRICARE. The results of this study will be instructive to all Federal health agencies and responsive to issues concerning provider participation in their health programs.

The AVAHS has advanced capability in telehealth with programs in the following: Coordinated Care Home Telehealth (HTM) serving 223 enrolled veterans; teleretinal imaging for screening diabetes patients for diabetic eye disease; teledermatology recently began operations in 2009; and telemental health provided by a psychiatric nurse practitioner serving over 60 unique patients per month. There is a planned expansion of telemental health including providing group counseling. In addition, AVAHS telemental health services have been offered to the Yukon-Kuskokwim Health Corporation, based in Bethel, AK, and the Maniilaq Association in Kotzebue, AK.

The AVAHS has also initiated programs to serve the rural population. A 3-year project has recruited Rural Veteran Liaisons to provide VHA outreach for three rural areas: Yukon-Kuskokwim, Kotzebue, and Nome. The Rural Health Care Pilot Project is another effort to reach rural veterans, in this case by mailing invitations to receive primary care and behavioral health services in Cordova, Bethel, Nome, Kotzebue, and Dillingham areas at the local Alaska Native facility. The VA has indicated that it plans to increase its outreach activities in order to reach these rural veterans.

The AVAHS has also worked closely with Alaska Natives through the Tribal Veteran Representative program that provided training on VHA and VA benefits to community volunteers. In addition, there is a tribally based program to provide outreach on VA and IHS benefits to returning service members. The AVAHS has also worked with the state of Alaska Department of Military and Veterans Affairs in a partnership to meet the needs of returning service members.

Community Health Centers

In 2008, there were 26 Community Health Centers (CHCs) in Alaska with most serving a rural population of low-income residents. 79% of patients at CHCs had incomes under 200% of the Federal poverty level. Approximately 77% of their patients were considered rural and 36% were Alaska Native. Medicaid paid about 22% of patient claims and Medicare about 8%. [12] The HRSA provided CHC grants totaling $48.9 million in 2009.

The role of CHCs has increased a great deal in the past decade, growing from just 10 clinics to 26 and over 100 sites providing care. In 2008, Community Health Centers saw 81,109 patients for 369,398 patient visits, compared to just 216,110 visits in 2002. The Accountable Care Act builds on this proven model of care to bolster and expand health centers over the next 5 years. It is important to note that some tribal health care clinics also receive funding from the HRSA, Bureau of Primary Health Care, but follow slightly different rules governing the provision of services. In Alaska, all or nearly all tribal CHCs see non-Indians in the small communities where they are often the only health care provider. Their sliding fee scale is not imposed on patients eligible for IHS-paid services. Challenges do remain for tribal programs due to HRSA reporting and performance requirements that make compliance difficult due to the unique circumstances of tribes.[13]

[12] Alaska Health Center Fact Sheet, National Association of Community Health Centers.

[13] Alaska Compact, Valerie Davidson. "Letter to Interagency Access to Health Care in Alaska Task Force Chair, Marilyn Tavenner." September 3, 2010.

The Alaska Federal Health Care Partnership (AFHCP)

The Alaska Federal Health Care Partnership (AFHCP), founded in 1994, has seven members including the Alaska Area Native IHS the Alaska Native Medical Center, and the Alaska Native Tribal Health Consortium. The U.S. Air Force is represented by the Commanders of the 673d Medical Group at Joint Base Elmendorf-Richardson and 654th Medical Group at Eielson Air Force Base. The army is represented by the Bassett Army Community Hospital at Fort Wainwright in Fairbanks. The Alaska Veterans Affairs Healthcare System based in Anchorage and the U.S. Coast Guard are also active members of the partnership and while the TRICARE Management Activity (TRICARE Regional Office West Alaska Office) is not a formal member, it has continued to actively participate as an invited guest. The purpose of the partnership is to collaborate wherever they can to improve access, leverage funding, optimize shared services, reduce costs, and increase health care capacity.[14]

The Home Telehealth Monitoring program (HTM) and Clinical Video Teleconference (CVT) project are two examples of successful programs of the Partnership. HTM places a small monitor in a patient's home and, with proper training, the patient and provider work together to monitor their vital signs. The system creates a "virtual road system" for patients among the 30% of Alaskans who are not on the road system. This innovative project currently involves 125 patients and 13 organizations.

The CVT project coordinated the purchase and deployment of video conferencing equipment that allows providers and administrators to visit sites virtually. Staff, clinicians, and patients are able to meet without incurring the costs of travel; both the expense and time involved are reduced dramatically with resulting cost savings. Peer-to-peer consultation is emphasized to enhance the quality of care. The Task Force heard several presentations about the acceptance of these technologies and viewed the equipment first-hand in rural sites.

The Partnership provides leadership in emergency preparedness planning, graduate medical education (GME) and also plays an important role in providing centralized resource and referral for telehealth consultations to support specialty care. The Partnership has also developed a service line providing training in topics including wound care, behavioral health, primary care management, healthy lifestyle, traumatic brain injury, suicide prevention, legal, ethical, and financial advice, and advice on accreditation.

The AFHCP supports various planning and provider workgroups including a Clinical Directors group that has identified top clinical priorities and capacity issues. This group has been very helpful in setting priorities for resource sharing agreements, including a neurosurgery agreement between the 3rd Medical Group at Elmendorf U.S. Air Force Base, Anchorage and the Alaska Native Medical Center, Anchorage. In addition to a recent (2009) perinatology agreement, the clinical directors have recommended the development of a comprehensive Federal pain management center in Alaska and the creation of an outpatient oncology infusion

[14] Paraphrased from "2009 Biennial Report", The Alaska Federal Health Partnership p. 2.

center, although these efforts have been constrained by the lack of a mechanism to easily pool resources.

The Partnership serves an important role in coordination between Federal agencies, tribes, and tribal health organizations. The Partnership has indicated that it stands ready to play a continued or larger role in the future to further promote coordination of Federal and tribal health agencies.

Barriers to Improving Health Status: The High Cost of Living in Alaska

It is no surprise that Alaska has one of the highest costs of living in the United States, ranking behind only California, New Jersey, and Hawaii as the most expensive state in the nation. Alaska and Hawaii's high costs are largely due to the distance from their main source of goods and services in the contiguous U.S. Unlike New Jersey and California, state and local taxes are not a factor in the state's high cost of living since the state does not have an income or sales tax. Alaska, more than most states, has higher costs due to the need to spend more on transportation for many services, the severe nature of its climate, and the related higher energy expenditures.

One unique aspect of Alaska's high cost of living is that its main metropolitan area, Anchorage, has a lower cost of living than its rural areas in every sector save housing. Anchorage, Juneau, and Fairbanks all have a cost of living equal to that of Seattle, WA, the city most closely tied economically to Alaska.[15] The only regions of Alaska that are lower cost than Anchorage are those communities within easy driving distance to Anchorage: the Mat-Su Borough and Glennallen Region. Areas with nearly identical cost of living include large population centers (relatively speaking) in Fairbanks, the Kenai Peninsula, and the small communities of Southeast Alaska (Ketchikan, Sitka).[16]

In stark contrast, the regional hub cities of rural Alaska, such as Dillingham, Bethel, Kotzebue, Nome and Barrow, have a much higher cost of living (about 150 % higher than Anchorage). At the extreme are the high costs of the remote villages of Alaska, most located on the rivers and coastline of western and northern Alaska and in the remote interior of northern Alaska.[17] Rural Alaska's extremely high cost of living is deserving of special consideration in any report on health care access. The casual observer might question why anyone would continue to live in such remote areas, but this ignores the ties to these homelands held by Alaska Natives and their fellow community members, many of whom provide critical services like health care to rural areas' largely (75%) Native population.

Alaska's business climate suffers from its high cost of living combined with its very high cost of transportation. The leading employers in the state are the Federal government and state and local government, along with the oil industry and other natural resource industries, which, because of Alaska's unique natural resources, will continue to operate in the state despite the high costs of doing so. Health care is dependent on government and resource industries, since it provides service to residents whose jobs are created by government or the resource industry. Because of the very limited refining and manufacturing base in Alaska, almost all natural resources recovered in Alaska are exported to the contiguous 48 before being sold to consumers or industrial users. Alaska produces 14% of all oil and 2% of all natural gas produced in the U.S., according to the Energy Information Administration.

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[15] "The Cost of Living in Alaska", *Alaska Economic Trends*, August, 2010, Neal Fried, p. 6.
[16] "The Cost of Living in Alaska", *Alaska Economic Trends*, August, 2010, Neal Fried, p. 5.
[17] "The Cost of Living in Alaska", *Alaska Economic Trends*, August, 2010, Neal Fried, p. 5 and page 8.

The Federal government is very active in Alaska with large military installations and its support of health and social services to Alaska Natives. Federal government expenses are largely supported by taxpayers in other states, and Alaska ranks near the top annually in the ratio of Federal expenditures in the state compared to Federal taxes paid by state residents.

The state of Alaska has prioritized containing costs in its strategic planning for health care.[18] Health care costs are soaring in Alaska. Compared to other cost growth contributing to Alaska's high cost of living, none comes close to health care's increase. Since 1982, health care costs have risen twice as fast as general inflation and 62% more than energy costs. [19] Health care is second only to housing in household spending.[20] These cost increases make it hard for Alaska employers to provide health insurance. The vast majority of employers in the state are small businesses of less than 50 employees, and staying competitive while attracting qualified employees is a challenge.

The Affordable Care Act Pre-Existing Conditions Insurance Plans and extension of dependent child coverage for young adults until age 26 will provide new insurance coverage in the short term, and the Exchanges, once implemented, will provide broad access to insurance that Alaska employers are unable to provide today. In addition, the cost-containment provisions of the Act, such as the Medicare Hospital Value-Based Purchasing Program, Payment Bundling provisions, and the ability to form Medicare and Medicaid Accountable Care Organizations may help reduce the cost of insurance to consumers. The ACA also provides exemptions to the employer mandate for all firms with fewer than 50 employees; moreover, small employers with fewer than 25 full-time equivalent workers earning less than $50,000 per year are eligible for a tax credit.

The source of funding matters in determining the impact health care has on Alaska's economy. One could argue that health care is a net gain for the state no matter the cost, given the extent of the funding which comes from outside the state to pay for health care services (such Federal dollars that pay for the health care of active military, military retirees, veterans, Alaska Natives, and Medicare beneficiaries, and the Federal share of Medicaid). Since a large share of costs are borne by Federal agencies, one might think that Alaska is somewhat protected against inflationary pressures, but the rising cost of health care cited in this report suggests otherwise. The ability for small businesses in particular to contain costs is a critical aspect of their profitability and growth.

It is clear that the high cost of living is an impediment to improving access to care in Alaska, but it is not an insurmountable one. Proposed improvements need to recognize the impact of Alaska's higher cost of living, with special attention to rural areas, and seek methods of expanding care through coordination of Federal agencies and their partners, and other means that minimize exacerbating medical inflation, while providing the high quality health care sought by Alaskans.

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[18] "Transforming Health Care", Alaska Health Care Commission, p 62.
[19] "The Cost of Living in Alaska", *Alaska Economic Trends*, August, 2010, Neal Fried, p. 4.
[20] "The Cost of Living in Alaska", *Alaska Economic Trends*, August, 2010, Neal Fried, p. 4.

Barriers to Improving Health Status: Workforce

Health care represents 9% of total employment and around 16% of the value produced by the state's economy with a payroll cost of $1.4 billion.[21] Health care costs are growing faster than the overall state economy. In fact, between 2000 and 2007, health care employment increased 40%, about five times faster than the state's population and twice as fast as the nation's health care workforce – reflecting, in part, the lack of medical infrastructure found in other parts of the U.S. This growth is estimated to continue.[22] Department of Labor and Workforce Development (DOLWD) data indicate a 30% growth rate between 2004 and 2014, twice that of the overall economy. There are an estimated 30,000 health care sector jobs in the state, and it is highly significant that these jobs exist in rural areas as well as Anchorage, Fairbanks, and Juneau. It is also notable that about 7,000 of these health care professionals work for federally funded Alaska Native tribes and tribal health organizations.

A private nonprofit state and tribal workgroup, the Health Workforce Planning Coalition, has produced a draft workforce plan titled *Alaska Health Workforce Plan*, which highlights occupations of chronic health care professional shortages including Behavioral Health Aide/Village Counselor, Primary Care Physician, Advanced Nurse Practitioner, Substance Abuse (and behavioral disorder) Counselor, Registered Nurse, Therapists, Nurse Educator, Pharmacist, Dentist, Psychiatrist, and Social Worker.[23] They have also developed a strategy they call, "Engage, Train, Recruit, Retain." They plan to engage the public and key sectors in the need for support of the health care workforce plan, support training for the health care workforce, recruit a new generation of health care workers, and focus on retaining the workforce with the support thought necessary to increase provider satisfaction.

While job growth is good news for the economy and job seekers with health care training, it also puts the health care industry in a race to catch up to growth from a base of severe existing labor shortages. The Alaska Health Workforce plan notes that "job growth puts heavy strains on an industry already burdened by unacceptable vacancy rates in key occupations."[24] These rates range from 12.9% for community health aides to 37.4% for pediatric nurse practitioners. Registered nurses had a comparatively moderate vacancy rate at 10.1%, which translates into 320 vacant positions.[25]

Workforce shortages in urban areas range from a complete lack of many specialists in Fairbanks and other towns, to a relative shortage of primary care providers and many specialists in Anchorage. For example, there is one perinatologist in the state and too few general surgeons to fully staff an integrated trauma system. Rural areas have far more difficulty attracting qualified candidates than Anchorage or Fairbanks. In the Task Force site visit to Fairbanks, Task Force members heard of a successful collaboration between the community hospital and a large medical practice that recruited 41 physicians over a 2-year period thanks to aggressive

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[21] *Alaska Healthcare Industry, Alaska Economic Trends*, March, 2010, Neal Fried, p 4.
[22] *Alaska Health Workforce Plan,* May, 2010, the Health Workforce Planning Coalition.
[23] *Alaska Health Workforce Plan,* May, 2010.
[24] *Alaska Health Workforce Plan,* May, 2010, p. i.
[25] *Alaska Health Workforce Plan,* May, 2010.

recruitment efforts. Concern was expressed, however, about retention and future recruitment in a time of expanding health care access under health care reform.

The authors of the Workforce Plan clearly believe that much of the Alaska workforce solution can result in positive career opportunities for Alaskans if most education and training takes place in Alaskan educational institutions and health care workplaces. It also recommends expanding positive out-of-state relationships, most notably the long-standing arrangement with the University of Washington School of Medicine'' Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) physician training program. This program allows a student to spend 2 years in Seattle on the UW campus and the rest of their training in a sponsoring state. The primary care physician shortage includes family practice, pediatrics, internal medicine, psychiatry, and internal medicine. The University of Washington is consistently ranked as the top training institution in the nation in primary care training. Alaska currently has 20 slots in WWAMI, and there is consideration of increasing this by 10 or 20 students per year. The Task Force heard from some of the providers they visited that they felt planning should begin now for a medical school in Alaska. Hospitals are also partnering to recruit and support pediatricians with residencies and, in the future, provide them with the research opportunities most desire.
The issue of workforce scarcity highlights health care as a double-edged sword for Alaska. It is in itself an important part of job growth, and high-quality health care is essential to attract industries and a high-quality general workforce. Still, expenditures that address health profession shortages further increase inflation in an industry that already experiences a higher rate of inflation than any other. The dilemma for Alaska is that some of the solutions to address perceived health care problems require a level of funding that exacerbates the inflationary spiral. The goal of fully staffing all vacant positions is a laudable one, but unlike other industries that are able to attract workers without the incentives and subsidies needed for the health care industry, most plans call for significant government spending.

Faced with the dilemma of the need to expend resources but a desire to lower medical inflation, policymakers have sought efficient and effective solutions to the issue of workforce scarcity. In addition, the state of Alaska has increased state-only funding for initiatives that have met the test of being an efficient solution through increased funding for additional slots in the WWAMI program. The state has also increased funding in state educational institutions to promote coursework, training, and practical experience to prepare the next generation of Alaska health care workers and re-train current workers. The Task Force heard many say that there is a role for Federal agencies to support state efforts that have set such clear goals, developed a sound strategy, and established consensus priorities. is the Task Force also heard that it is essential that Federal health agencies coordinate their efforts with State efforts that are, in many areas, already underway.

Barriers to Improving Health Status: Trauma System

As documented in a recent American College of Surgeons review Alaska has developed many creative programs to mitigate the long distances patients must travel and the limited health care infrastructure.[26] Although traumatic injuries are one of the leading causes of death, disability and illness in Alaska, there is no integrated trauma system to coordinate care. Alaska Native Medical Center is the only Level II certified trauma center in the state; hence, it receives all appropriate emergency cases from the Anchorage municipality in addition to Alaska Native patients from around the state. There are no Level I trauma centers and no central function to identify the best location to which to transport trauma patients. Movement of trauma patients relies on the USCG and State Guard air assets, as well as several privately-owned air transport services. The state legislature recently funded a full-time employee to begin collecting and analyzing data to help design a more robust trauma system. Recent state legislation has created a series of incentives for hospitals to become certified trauma centers, but, because many specialists do not work for the hospitals most likely to receive trauma patients, it is unclear if these incentives will motivate physicians to support hospital-based efforts to build an integrated trauma system.

Because of the remote location of many villages and the absence of roads, aviation remains the primary means of transporting trauma patients to higher levels of care. As the numerous aviation accidents this summer in Alaska highlight, aviation in this state continues to carry real risks. Substantial progress has been made in improving aviation capabilities in communities across Alaska, but there is an ongoing need to continue to improve air fields and other aviation-related infrastructure.[27]

Due to the need for military medics to maintain their trauma skills, military leadership have expressed interest in partnering with the Anchorage community to provide the level of care found in similarly-sized cities in the contiguous 48. A shortage of key specialists who are willing or able to take call continues to impede efforts to move forward and could be mitigated by a partnership similar to that which was created in San Antonio, Texas, in which military hospitals helped provide trauma care, regardless of beneficiary eligibility. The Tacoma Trauma Trust provides an excellent model of a successful public-private partnership which addressed similar challenges in that community.[28]

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[26] American College of Surgeons Committee on Trauma. (2008, November 2-5). "Trauma Systems Consultation."
[27] Federal Aviation Administration. "Aviation Access to Remote Locations in Alaska: Study for House and Senate Appropriations Committees (May 2001)."
[28] Tacoma News Tribune, "ER Two Step" (June 27, 2010).

Primary Care Physician Shortage for Medicare Patients

The difficulty a new patient faces finding a participating Medicare provider in Alaska is well documented. Three separate reports by the Institute of Social and Economic Research at the University of Alaska-Anchorage document the nature of the problem and suggest several proposed solutions.[29] Patients with Medicare who have a provider and those who age into Medicare have not reported as much difficulty keeping their current primary care physician, but some have been told by their provider that they will not continue to provide care once Medicare is their insurance. It is also evident that the problem is most severe in Anchorage, with some reports of similar problems in the Mat-Su region/Wasilla.

The Task Force heard from providers in both Fairbanks and Anchorage that back up the reports' finding that the main reason physicians give for not wanting to add new Medicare patients is their perception of Medicare's inadequate reimbursement. Like providers in other states, Alaska providers also cite the paperwork associated with Medicare. In a strikingly larger percentage than their counterparts in other states, Alaska providers are fearful of Medicare audits (61% of Alaska providers cite this concern compared to just 28% nationwide).[30]

Attempts to ensure that TRICARE and Medicaid payments are fair to Alaska providers have made Medicare participation less likely. In most states TRICARE care pays Medicare rates, but under a demonstration extended through December 31, 2012, TRICARE pays 40% above baseline more than Medicare. The increased payment rates have demonstrably improved provider participation rates. Medicaid rates in the state are relatively generous, and most agree they cover the cost of the care provided. Medicare is the lowest payer of the six major payers in the state according to a recent report by the Institute of Social and Economic Research at the University of Alaska.[31] Since there is a shortage of primary care providers throughout the state, providers have great latitude to choose which people they will add to their patient lists. It is this combination of low reimbursement rates, provider shortage, and small patient base that makes it difficult for the provider community to justify extending services to a payer and patient population that requires a subsidy to cover the full cost of the provision of health care services. Medicare has the lowest reimbursement level of the six primary payers of health care in Alaska: employer-paid health insurance, individually purchased health insurance, Medicaid, VHA or TRICARE.

Alaska has one of the lowest percentages of Medicare patients in the nation. Anchorage has 26,282 seniors who are 65 years or older, and this population is expected to grow to 36,635 in 2014. Only 8% of Alaskans are enrolled in Medicare compared to 15% nationally. When one considers the overall primary care provider shortage it is certainly true that the typical physician can have a viable practice in Alaska without serving any Medicare patients.

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[29] Frazier, Rosyland, and Mark Foster. "Improving Health Care Access for Older Alaskans: What Are the Options?" Institute of Social and Economic Research at the University of Alaska, Anchorage, June 2010.
[30] Ibid, p.14.
[31] Ibid, p. 15.

Current Alaska Initiatives to Address Provider Shortage

While no one has suggested that private, state, and nonprofit organizations have solved the Anchorage Medicare primary care provider crisis, three initiatives, described below, have begun to tackle the need for access to care for Anchorage's senior population on Medicare. In addition, steps have been taken by TRICARE to increase provider participation, including the TRICARE rate demonstration (described on page 21) that increased rates for providers.

Each of the three initiatives that follow has recently secured firm funding, has advanced to the next step beyond planning, and hopes to expand access to a significant number of Medicare patients within the next 12 months. These initiatives are summarized below. Readers should note, however, that many expressed concern to the Task Force about the sustainability of these initiatives to provide a long-term solution to the current primary care provider crisis. Many believe that Medicare patients will continue to find it hard to secure or keep their doctor unless the factors that are thought responsible for the problem are addressed.

Providence Alaska Medical Center Senior-Care Clinic

The Providence Senior-Care Clinic is in the advanced stages of planning, with an opening set for 2011. The clinic will operate with an explicit subsidy from Providence Alaska Medical Center estimated to be in excess of $200,000 annually. It will specialize in patients 55 and older. The clinic plans to use a patient-centered medical home model. It is hoped that this model will reduce the overall cost of caring for high-need or chronic care patients. Some of the descriptions of the clinic reference the Nuka model used at the Southcentral Foundation in Anchorage, but there is no direct link or joint planning between the two organizations on the Senior-care clinic.

The Alaska Neighborhood Health Clinic

This Community Health Center will expand its existing Medicare patients' services thanks to two funding sources. The first is a $9.7 million appropriation from state of Alaska general funds for the construction costs of an expanded clinic. The second is a pledge of about $250,000 annually from the Providence Alaska Medical Center for increased senior care.[32] The clinic saw 1,828 patients 65 and older in 2009, 20% of whom did not have Medicare Part B coverage. It is unclear why such a large percentage did not have Part B coverage.

The Alaska Medicare Clinic, Inc.

This 501(c)(3) nonprofit organization will operate a high-efficiency senior clinic that focuses on lower-need patients with a rigorous protocol emphasizing efficient patient flow. A single physician at the clinic will spend limited time with each patient after the work-up by a medical assistant and nurse practitioner. It is expected that the nurses will see 24 patients per day, while the physician sees 32. The startup costs of $1.5 million will be raised with an initial state of Alaska general funds appropriation of $1,000,000 in SFY 2011 and private sector funding for the balance. While the other two initiatives appear to enjoy broad support, this option has

[32]Shinohar, Rosemary, *Anchorage Daily News*, "Providence Plans to Open Clinic for Seniors: Official Hope Facility will Slow Local Medicare Crisis," June 5, 2010.

raised more concerns than the others. The concerns are mainly about how the plan seems to select healthier patients, leaving the more complex cases for other providers.

Telehealth and Health Information Technology

Alaska stands at the edge of a technological revolution in health care. It is in many ways the nation's most technologically challenged and most technologically advanced state. The factors of remote location, expansive size, and low population density all impact the need and also the difficulty of providing up-to-date technology for the state's health care system. Federal agencies have been at the forefront of the technological revolution in health care in Alaska for over 25 years. Tribal health programs are the largest user of Health Information Technology in the state and perhaps the nation.

The Task Force met with the Director of Alaska Federal Health Care Access Network (AFHCAN), a federally funded, tribally operated telehealth program. AFHCAN provides telehealth software, hardware, network, and business solutions to medical facilities serving Federal beneficiaries in Alaska, including "AFHCAN carts" with hardware that relays information from a remote location to a clinician. It began as a project in 1998 under the auspices of the Alaska Federal Health Partnership to improve health care for Federal beneficiaries using modern telehealth technology for home monitoring of vital signs. The project has conducted detailed evaluations of its services and it is a record of success. The Task Force heard that some CMS and state regulations sometimes make it difficult to receive payment even though telemedicine saves the Medicaid and Medicare programs money thanks to early diagnosis resulting in early access to specialist care. There are also large savings in medical transportation.

The AFHCAN project was designed to provide telehealth systems to 248 sites throughout Alaska represented by 43 autonomous organizations. These sites provide direct care to beneficiaries of IHS and tribal organizations, the DoD, U.S. Coast Guard, and the VA. The project also provides benefits to state Public Health Nursing (PHN) offices. In total, the beneficiaries served by the AFHCAN sites represent approximately half of the state's total population.[33] DoD beneficiaries have had only limited access due to existing DoD security policies which limit the use of telehealth equipment in military medical facilities.

New legislation has provided Alaska with much-needed financial resources and national direction to an effort that is already well advanced when compared to other states. The Health Information Technology for Economic and Clinical Health (HITECH) Act goals fit Alaska well. It is designed to provide the necessary assistance and technical support to providers, enable coordination and alignment within and among states, establish connectivity to the public health community in case of emergencies, and ensure the workforce is properly trained and equipped to be meaningful users of EHRs.

In addition to the AFHCAN and the Federal Partnership, another new organization, funded through the American Recovery and Reinvestment Act of 2009 is the recently established

[33] "The Impact of Store-and-Forward Telehealth in Alaska: A Seven-year Retrospective: Impact and Experiences from Seven Years of Utilization within the AFHCAN System", Ferguson, A. Stewart Ph.D., John Kokesh M.D., Chris Patricoski M.D., Phil Hofstetter, Nathan Hogge, 2009.

Alaska eHealth Network, an organization that operates as a Health Information Exchange Network and a Health Information technology assistance center.

The state of Alaska was awarded $4,963,063 for the State Health Information Exchange Cooperative Agreement Program. In April 2010, Alaska Department of Health and Social Services contracted with the Alaska eHealth Network (AeHN) to be the nonprofit governing board that will procure and manage Alaska's health information exchange (HIE) grant program that supports States or State Designated Entities (SDEs) in establishing HIE capability among health care providers and hospitals in their jurisdictions. Two vendors have been selected as the preferred providers of EHRs supported by the HIE. This effort will assist providers achieve meaningful use in order to receive incentive payments from CMS's Medicare and Medicaid programs.

Alaska eHealth Network was also awarded $3,632,357 for the Health Information Technology Extension Program, a grant program to establish Health Information Technology Regional Extension Centers to offer technical assistance, guidance, and information on best practices to support and accelerate health care providers' efforts to become meaningful users of Electronic Health Records (EHRs). The Task Force learned that many health care practices in the state are small, and the majorities do not have EHRs. This is one area where Alaska will have to catch up with other states by promoting the new funding opportunities for providers. The Alaska eHealth network has selected two preferred EHR systems and Providence Health System is offering to subsidize the cost and arrange for the adoption of the EHR (EPIC) used by the Hospital for providers associated with the hospital.

The ability of the VA and DoD medical facilities to participate in the Alaska eHealth network remains unclear, due to the lack of clear guidance over who will pay for Federal medical facilities to participate in State initiatives such as the one in Alaska. As governments or Native corporation-funded healthcare organizations adopt electronic health records, it is recommended that they choose those which will be compatible with the AeHN.

In summary, Alaska is well positioned to take advantage of new funding opportunities that seek to expand electronic health records, interconnectivity, and telemedicine in the state. With over 20 years of experience in telemedicine and infrastructure development, the state stands poised to demonstrate how health information technology meet the challenges unique to Alaska and those common to all states.

Task Force Findings

Federal health agencies have made great strides in providing health care services to their beneficiaries under difficult circumstances. Many new facilities have been constructed since 1995, and a dedicated workforce has markedly enhanced services. There are, however, serious gaps in health care services in Alaska. Many of these gaps are due to Alaska's unique challenges due to its remoteness, small population base, and vast distances that result in some of the highest costs for providing services in the U.S. Alaska does benefit from a number of special payment policies targeted at rural communities. The following summarizes the key findings resulting from the Task Force's efforts.

Regulatory Flexibility and Simplification

- Greater inter-agency collaboration may be necessary to assure that overlapping policies are not unnecessarily inhibitive of health care access in Alaska. Agencies should consider opportunities to promote greater regulatory flexibility given Alaska's unique demographic and logistical circumstances.

Federal Reimbursement

- Physicians, non-physician practitioners and others in the provider community have expressed dissatisfaction with Federal reimbursement rates that they view as inadequate and unfair to Alaskan providers. Many in the provider community believe that a fair, adequate, and uniform Federal rate would alleviate existing provider shortages in Alaska.

- The recent increases in IHS funding in the past two budgets have partially restored its purchasing power to pre-2002 levels.

Workforce and Training

- Rural Alaska has significant problems relating to provider shortages and health care costs. Many rural areas also have social determinants of health that underscore the need for more robust and cost-effective health care delivery models.

- Workforce shortages exist in many areas and there is consensus that some priority occupations and sub-specialties deserve immediate action, including primary care and psychiatric inpatient care.

- There is a shortage of primary care Medicare providers in Alaska, a problem most severe in Anchorage, but evident in Fairbanks as well as in rural Alaska.

- The Anchorage area has grown to the point where it now meets the threshold of size and resources necessary to sustain the higher level of care typically found in similar-sized cities.

- There is a need for an integrated state trauma care system and a second Level II trauma care center in Anchorage in addition to the existing Alaska Native Medical Center.

Health Information Technology

- There is a need for improvements in health information technology, building on a long history of innovation and practice that sets the IHS (and Alaska Native Tribal Health Consortium), VA, DHS (U.S. Coast Guard) and DoD in Alaska apart as leaders in telemedicine. However, the interconnectivity necessary for coordination of care through electronic health information exchange is lacking. Federal agencies do not have coordinated mechanisms for paying for participation in integrated health information systems. Federal inoperability efforts are consistent with NHIN policies, practices, and standards.

Participation in Formal Coordinating Organizations

- There are current longstanding and more recent examples of joint planning, coordination of services, and resource support for programs that can serve as vehicles for increasing capacity and capability, including the Alaska Federal Health Care Partnership and the Denali Commission although both are constrained by available resources.

- Federal agencies are the largest payers for the state's medical transportation including a somewhat uncoordinated emergency Medevac system and routine medical transportation, with Medicaid and Medicare paying over $100 million annually for transportation, the VA over $4 million, and DoD over $12 million.

- Medical transportation would benefit from more coordination among the Federal agencies.

- Although some of these gaps in health care services have been addressed with innovative thinking to produce programs and organizational structures to address unique Alaskan conditions, the report outlines additional steps to build on this progress.

Task Force Recommendations

The Task Force makes the following recommendations to improve communication, capacity, and capability in order to respond to the degree of difficulty presented in Alaska and to raise health care services in Alaska to meet the level that can be achieved in the rest of the nation.

Regulatory Flexibility and Simplification

- Each of the Federal agencies providing benefits, services, or both to Alaskans should, in collaboration with other agencies when necessary, conduct a regulatory review of policies that may inhibit interagency collaboration or access to benefits or services. Agencies should consider regulatory modifications or granting enhanced flexibility to promote Alaskans' access to higher-quality, cost-effective and better coordinated health care. Examples include the DoD/VA's ability to develop Joint Incentive Fund (JIF) agreements, and possible expansion of the concept to other Federal agencies. Another is the waiver flexibility of TRICARE for purchasing specialist care that is not available to other agencies.[34]

Payment Reform and Flexibility

- Federal agencies providing health care reimbursement should support current projects to develop a budget-neutral, uniform provider reimbursement rate for similar services for Medicare, TRICARE, and the VHA.

- We applaud the CMS' development of a multi-payer medical home demonstration and encourage other Federal agencies to consider similar demonstrations.

- Federal agencies that reimburse for medical transportation should consider collaborating to develop budget-neutral, unified policies and supplier rates in areas in Alaska where medical transportation is particularly limited or difficult. An update of the Federal Aviation Administration (FAA) survey may be needed to refine earlier recommendations

- We support Indian Health Service funding increases as reflected in the FY 2011 President's budget request to reduce health disparities experienced by American Indian and Alaska Native populations..

- Federal payers that do not already do so should consider enhanced reimbursement rates for primary care providers furnishing services in shortage areas or who are representative of workforce shortage professions.

Workforce and Training

- After the reallocation of Medicare-sponsored Graduate Medical Education residency slots has occurred (subject to sections 5503 and 5506 of the Affordable Care Act) Federal agencies sponsoring residencies in family medicine, internal medicine, pediatrics, and psychiatry should conduct an in-depth analysis of the adequacy of Alaska's workforce

supply in these specialties and consider additional budget-neutral measures that would enhance and support physician and non-physician practitioner supply to Alaska.

- The Federal health agencies in Alaska are willing to coordinate and promote with other partners in the health care community to utilize their diverse clinical practices to support additional residencies in family medicine and the initiation of new residencies in internal medicine, pediatrics, and psychiatry.

- Federal agencies should look for opportunities to partner with existing training offerings rather than operating training programs that are exclusive to their own agency. Federal agencies should also seek out training at the University of Alaska or other educational offerings in the state rather than develop their own training programs in every case.

- Additional opportunities to improve the availability of providers should be explored including the development of reciprocity agreements with states in the Pacific Northwest to allow providers licensed in those states to practice in Alaska and expedite the process of granting Alaska licenses to medical professionals.

- The DoD and VA) should develop a single credentialing process which allows a provider to accomplish this task one time and work in either DoD or VA facilities.

- Federal agencies should analyze the merits and the feasibility of adapting the successful Federal-private partnerships in San Antonio and Tacoma to support the development of an integrated state trauma care system, including additional Level II trauma centers.

Health Information Technology

- Federal agencies should coordinate efforts to promote adoption of interoperability between the electronic health records (EHRs) of DoD, VA, and the IHS, perhaps as a demonstration project. Anchorage, with its robust interagency relationships, is an ideal next location for piloting the Virtual Electronic Lifetime Record (VLER).

- The agencies represented on the Task Force, the Denali Commission, the Federal Communications Commission, the United States Department of Agriculture and the HRSA should coordinate efforts to streamline and combine grant opportunities, where possible, to expand broadband access throughout the state.

Participation in Formal Coordinating Organizations

- Expand opportunities for Federal health agencies to collaborate with the state of Alaska Health Commission.

- Expand Alaska Federal Health Care Partnership to include other agencies of the HHS to foster greater coordination with enhanced accountability and transparency.

Outreach

- All Federal agencies that provide health benefits, coverage, and/or services should coordinate outreach, enrollment, and benefits counseling to the extent practicable. Federal agencies should also cross-reference partner Federal agencies in their printed and website materials.

- Federal agencies should analyze the merits of adapting existing web portals to create a single portal for use by US citizens to determine eligibility for medical benefits.

Endorsements

In addition to the Task Force recommendations, we also lend our support to recommendations from other groups that have analyzed access to health care in Alaska with the following endorsements:

- Conducting a feasibility study for the establishment of a Medical School in Alaska.

- Increasing the number of the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) slots for training primary care physicians.

- Continuing FAA efforts to improve aviation infrastructure in Alaska to enable medical evacuation flights to communities which lack other means of accessing appropriate health care.

Conclusion

The Task Force heard consistent themes throughout its visit to Alaska. One theme was simply that to understand Alaska's challenges one has to see it firsthand, and the site visits allowed the Task Force to do just that. By travelling from the Kenai Peninsula to Fairbanks and on to Galena and Nome, the Task Force got a sense of the state's unique geographic and demographic characteristics. Tours of military treatment facilities at Fort Wainwright, Joint Base Elmendorf-Richardson, and two Veterans Community Based Outpatient Clinics highlighted the important role of the military and the Department of Veterans Affairs in the economy and health care system of Alaska. Finally, the outstanding success of tribal self-governance operated facilities throughout the state, made it clear that Alaska Natives have put forth a huge effort to achieve their vision for a healthy Alaska Native population in ways that may be instructive for other health systems.

Visits to Nome and Galena made it clear that high costs are not exaggerations but the reality of rural Alaska. The visits also made it clear that Alaska has made progress through innovative programs and technologies. AFHCAN telemedicine carts were on display as well-used extensions of health care expertise projected across the vast distances of the state. These carts, with their store and forward technology, were seen in remote locales, and the Task Force heard the evidence of the resulting improvement in outcomes for patients in presentations in Anchorage. The self-monitoring of patient vital signs in rural Alaska were not just promising, but proven technologies. These technologies would not have achieved such positive results without the cooperation of the Federal agencies. The theme of cooperation was also heard in every setting, and its value was clearly demonstrated in the advances that occurred with the modest investments made by the Alaska Federal Health Care Partnership.

It is significant that the Task Force was told of numerous problems, but more significant still, it heard of the progress toward solutions Alaskans have made working together in the public and private sectors, with state agencies, and with Federal partners. The state has made great progress in setting its own agenda for change by defining the problems it faces, and importantly, by prioritizing solutions to problems it faces in the key areas of health information technology and workforce capacity. There is little doubt that the state will move forward in the areas they have identified for short term action, but many of their long-term goals depend on cooperation by the Federal agencies with health responsibilities in the state.

The recommendations are the Task Force's best effort to respond to what we have learned, to mobilize the agencies that we represent, and to make a difference by acting in concert with the plans that Alaskans have made for themselves as they ask Federal agencies to partner in the efficient and effective delivery of the highest quality health care.

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'SEC. 5104. INTERAGENCY TASK FORCE TO ASSESS AND IMPROVE ACCESS TO HEALTH CARE IN THE STATE OF ALASKA.

''(a) ESTABLISHMENT.—There is established a task force to be known as the 'Interagency Access to Health Care in Alaska Task Force' (referred to in this section as the 'Task Force').

''(b) DUTIES.—The Task Force shall—

''(1) assess access to health care for beneficiaries of Federal health care systems in Alaska; and

''(2) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska.

''(c) MEMBERSHIP.—The Task Force shall be comprised of Federal members who shall be appointed, not later than 45 days after the date of enactment of this Act, as follows:

''(1) The Secretary of Health and Human Services shall appoint one representative of each of the following:

''(A) The Department of Health and Human Services.

''(B) The Centers for Medicare and Medicaid Services.

''(C) The Indian Health Service.

''(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.

''(3) The Secretary of the Army shall appoint one representative of the Army Medical Department.

''(4) The Secretary of the Air Force shall appoint one representative of the Air Force, from among officers at the Air Force performing medical service functions.

''(5) The Secretary of Veterans Affairs shall appoint one representative of each of the following:

''(A) The Department of Veterans Affairs.

''(B) The Veterans Health Administration.

''(6) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.

''(d) CHAIRPERSON.—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), selected from among the members appointed under paragraph (1).

''(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.

''(f) REPORT.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

''(g) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (f).''