

Health Care in Alaska

Prepared for Alaska Health Care Commission by
Section of Health Planning & Systems Development
Division of Public Health
Alaska Department of Health & Social Services

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Part I. How health care in Alaska is provided

A. Organization of health care delivery systems in Alaska

People in Alaska obtain care for health needs through three different systems: the private sector, the military and Veterans Affairs (VA) health system, and the Alaska Tribal Health System. The “private sector” can be defined as any services provided outside of the military/VA or tribal systems. It includes hospitals, physicians, dentists, mental health and substance abuse professionals, and various kinds of clinics. It also includes a wide array of support services such as pharmacies, imaging centers, renal dialysis centers, medical supplies and equipment sales and service, medical transportation services, nursing homes, rehabilitation centers, residential psychiatric treatment facilities, and home care and hospice.

The tribal and governmental systems represent a larger portion of both facilities and service providers in Alaska than in other states, with nearly 20% of the population (about 140,000) eligible for services in the tribal system, and 12% percent (about 87,000) are covered by the military system. (In the U.S. as a whole the proportions are 2% tribal and 5% military.)¹

In Alaska, services that are provided by federal governments directly (rather than through reimbursement or an insurance program) are mostly Veterans Affairs and military services for active duty and former service people in the Army, Air Force, and the Coast Guard. State and local government services are limited primarily to the state psychiatric hospital, Pioneer Homes, public health services,² and some locally owned and operated clinics. Governments also play a major role in reimbursing private and tribal providers for the costs of providing care (rather than providing care directly) through Medicare, Medicaid and other programs. Governments also contract with or provide grants to private, tribal and for-profit organizations to provide services.

Alaska’s health services have evolved in response to many factors including geography, population needs and traditions, and historical events. The dispersal of the communities across a huge, mostly roadless territory accounts in large part for the creation of the innovative statewide health system. Many of Alaska’s hospitals are former tuberculosis control hospitals built by the U.S. Public Health Service to treat the epidemic of the early 20th century. Then Alaska’s location gave it a critical military and communication defense role for the country during World War II and during the Cold War of the 1950s and 1960s. The major role of the federally recognized tribes in planning and implementing a coordinated system of care for Alaska Natives, through an agreement with the Indian Health Service called “compacting,” has supported and determined the development of care in rural areas of the state.

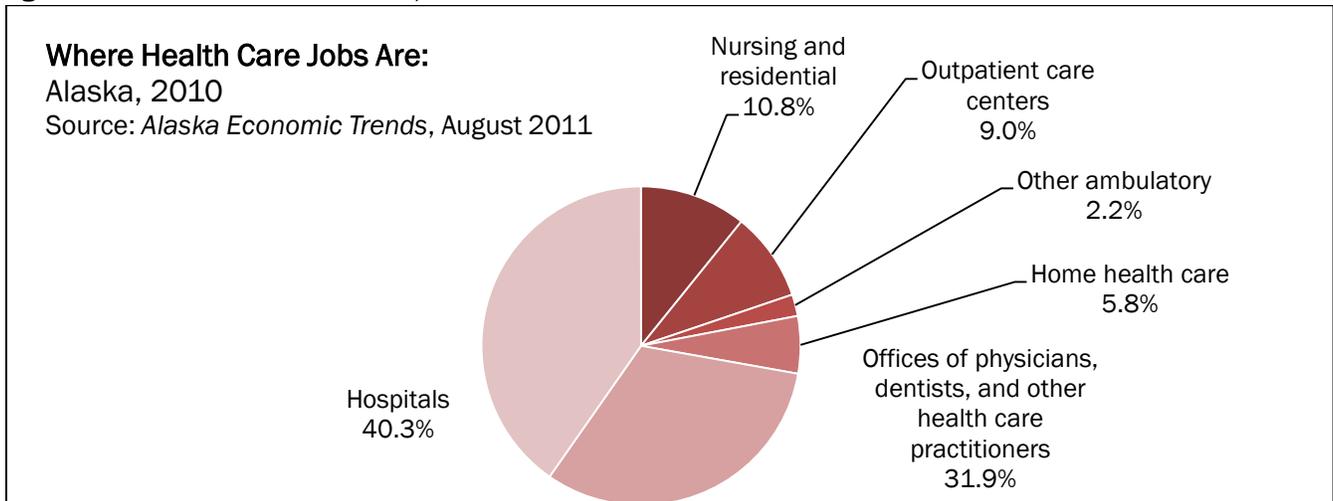
Health care is a major contributor to the state’s economy, with nearly one in 10 jobs in health care. Just over 40% of the 31,837 jobs in health care are in hospitals; hospitals are also among the largest employers in the state.³

¹ American Community Survey (2014). Health Insurance Coverage by Type, 3-year average 2010-2012.

² Services include immunizations, well child care, services related to infectious diseases, sexually transmitted disease screening, treatment and partner management, newborn hearing screening, family planning, and home visits for follow-up on referrals of high risk families with children.

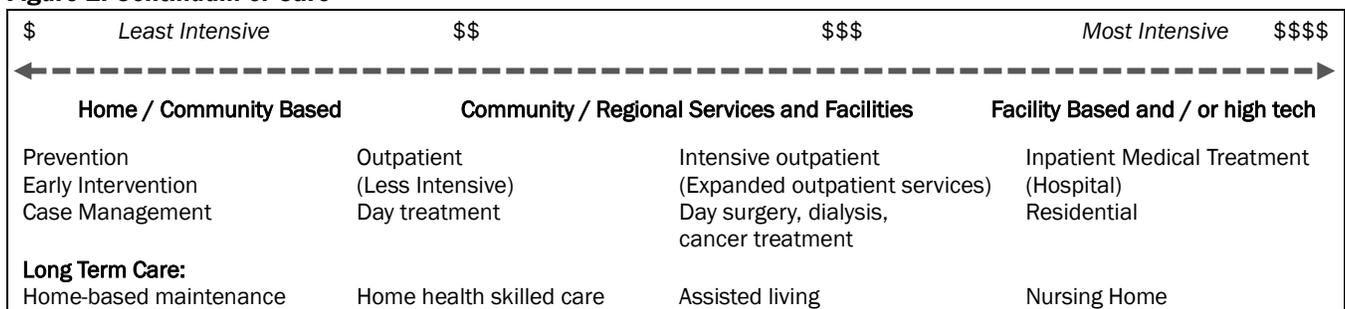
³ Alaska Department of Labor and Workforce Development (2011). *Alaska Economic Trends* 31:8. Available at <http://labor.state.ak.us/trends/aug11.pdf>.

Figure 1: Alaska's Health Care Jobs, 2010⁴



Thinking of health care services as a “continuum” of care from prevention through treatment, rehabilitation, and maintenance of optimum health can help one comprehend the many different services, facilities and programs. A simplified graphical presentation shows relationships of some of the key components in Figure 2.

Figure 2: Continuum of Care



1. Private Health Care Sector

The private health care sector includes an array of services from primary care, prevention, and supporting services to highly specialized diagnosis and treatment. Firms range from self-employed professionals, small businesses, and non-profit organizations to national corporations. Not-for-profit health services include very large entities like Providence Alaska Health Systems, with more than 4,000 employees statewide.⁵ Seattle, Washington is still the nearest source for some highly specialized services such as heart and other organ transplants and severe trauma treatment.

Three of Alaska’s hospitals are for-profit entities: Alaska Regional Hospital, Mat-Su Regional Medical Center, and North Star Behavioral Health. Additionally, many of the free-standing diagnostic, treatment, and ambulatory surgery facilities are for-profit entities. Many private-sector physicians, dentists, psychologists and other practitioners are self-employed or have incorporated to pay themselves and staff salaries, while others are employees of hospitals and other organizations. Drug stores, medical supply companies, and other support services are largely for-profit firms.

⁴ Alaska Department of Labor and Workforce Development (2011). *Alaska Economic Trends* 31:8. Available at <http://labor.state.ak.us/trends/aug11.pdf>.

⁵ “About Providence.” Accessed 4/2/2014. <http://alaska.providence.org/choose/pages/about.aspx>.

Private not-for-profit entities can include facilities such as birth centers, or organizations such as Anchorage Project Access which provide care for those unable to pay. Private not-for-profit organizations also include Community Health Centers and Community Mental Health Centers that receive grants from federal government programs.

Alaska has no managed care organizations or health maintenance organizations in the private sector. However, informal referral patterns and “preferred providers” associated with a variety of insurance programs result in some structured relationships, and some facilities and groups are affiliated or jointly managed.

2. Tribal Health System

Alaska has 228 federally recognized tribes, accounting for about 140,000 people. Alaska Native villages are situated mostly along the coast and rivers of rural Alaska. As part of its trust responsibility to Native people, the federal government is required to provide a basic level of health care services to the American Indians/Alaska Native (AI/AN) population.

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of 39 tribes and tribal organizations providing health services to AI/AN in Alaska.⁶ The ATHS is a diverse and multifaceted health care system that has developed over the last 30 years since passage of the 1975 Indian Self-Determination and Education Assistance Act (ISDEA, Public Law 93-638). Each of the tribal health organizations within the ATHS is owned and operated independently, while remaining interconnected via the system’s sophisticated patterns of referrals and their primary and common mission of improving the health status of Alaska’s AI/AN population.

The Indian Health Service (IHS) manages the Alaska Area Native Health Service Office (one of 11 IHS Area Offices) that works in conjunction with nine tribally operated service units to provide comprehensive health services to Alaska Native people. IHS-funded services are delivered by tribal health organizations or under contract with non-tribal service providers. About 99% of the IHS Alaska Area budget is allocated to Alaska Native Tribes and Tribal Organizations operating under IDEAA.⁷

The Alaska Native Tribal Health Consortium (ANTHC) was organized as a statewide non-profit health service organization owned by Alaska Natives and managed by all tribes in Alaska. ANTHC employs over 2,000 people⁸ and manages the statewide health services formerly provided by the Indian Health Service. ANTHC has responsibility for essential statewide services, including the Alaska Native Medical Center (ANMC), a 150-bed facility in Anchorage that serves as the referral center for specialty care. ANMC is co-managed by ANTHC in conjunction with Southcentral Foundation, the tribal health organization serving Anchorage and the surrounding communities.

The other tribally administered hospitals are located in the six rural communities of Sitka, Barrow, Bethel, Dillingham, Kotzebue and Nome. IHS holds title to these hospitals (former U.S. Public Health Service hospitals) as well as three tribal health centers (St. Paul Island, Annette Island and Tanana Village) and is responsible for their maintenance. There are 44 tribal health centers and 160 tribal community health aide clinics, and five residential substance abuse treatment centers.⁹ In many rural areas of the state tribal health organizations are the only health care providers available, and serve

⁶ Alaska Tribal Health System. “ATHS Members.” Available at www.alaskatribalhealth.org/about/contacts/index.cfm.

⁷ Indian Health Service. “Alaska Area.” Available at <http://www.ihs.gov/alaska/>.

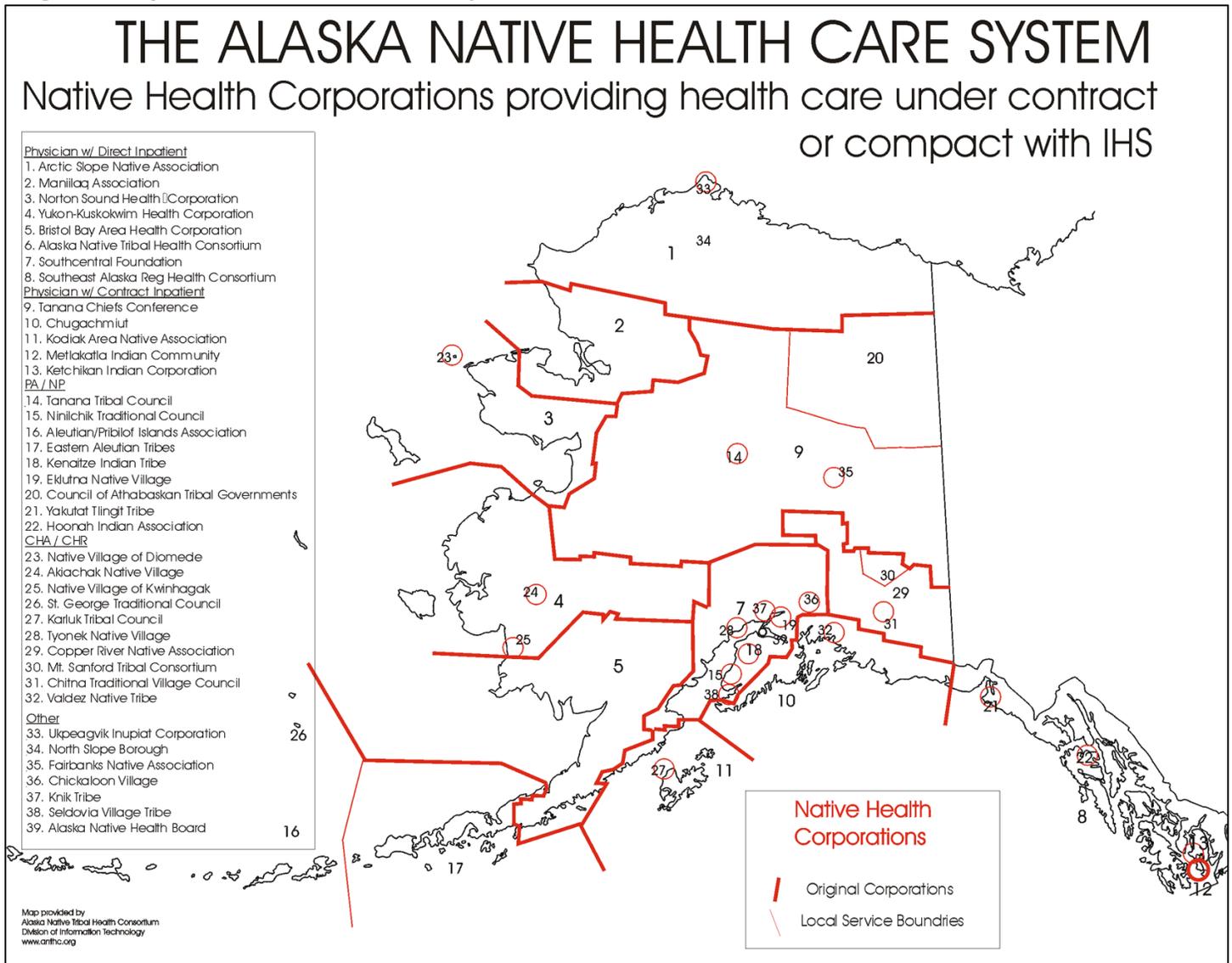
⁸ Alaska Native Tribal Health Consortium. “Who we serve.” Available at <http://anthctoday.org/about/serve.html>.

⁹ Indian Health Service. “Alaska Area.” Available at <http://www.ihs.gov/alaska/>.

everyone in the area regardless of race or IHS-beneficiary status.

The Alaska Tribal Health Compact, which authorizes tribes and tribal health organizations to operate health and health-related programs, was formed October 1, 1994. The Compact (also identified as P.L. 93-638, Title V Self-Governance Compact) is the umbrella agreement that sets forth the terms and conditions of the government-to-government relationship between Alaska Native tribes and/or tribal organizations, and the United States government through the Indian Health Service. Other “compact” organizations include the tribal health corporations that serve regions and specific communities. There are 25 tribes and tribal organizations that belong to the Title V Compact; in addition, there are 13 tribes and tribal organizations that contract with the Indian Health Services to provide health services under P.L. 93-638, Title I.

Figure 3: Map of Alaska Native Health Care System¹⁰



¹⁰ Alaska Native Tribal Health Consortium, Division of Information Technology. Available at <http://www.anthc.org/ref/maps/>.

3. U.S. Military and Veterans Affairs Systems

U.S. Department of Defense

About 50,000¹¹ active duty military and their dependents in Alaska are eligible for health care services provided by the Department of Defense. Military retirees and veterans (numbering 74,671 as of September 30, 2013)¹² also have access to certain services. Two major health centers serve military personnel: Joint Base Elmendorf Richardson (JBER) Hospital outside of Anchorage, and Bassett Army Community Hospital near Fairbanks. Nearly 20% of the population of Anchorage is eligible for care at the JBER facility.¹³

When a patient requires highly specialized care, he or she may be referred to a private sector hospital or, more often, to military medical centers out of state. The military has medical centers to serve local military installations in Alaska as well as to provide for surge capacity in times of emergencies. Alaska's military forces have the capability of airlifting complete surgical and hospital facilities to any part of the world or to provide services in times of national emergencies.

Alaska Veterans Administration (VA) Healthcare System

The Alaska VA Healthcare System and Regional Office offer primary, specialty, and mental health outpatient care. Services are provided at the Anchorage VA Medical Center, on Joint-Base Elmendorf Richardson, and through fee-based arrangements with community hospitals and health centers. The VA Medical Center in Anchorage also features a comprehensive Homeless Veteran Service consisting of a Domiciliary Residential Rehabilitation Treatment Program, Veterans Industries, Psychosocial Residential Rehabilitation Treatment Program, VA Supported Housing Program and outreach. In response to a long waiting list resulting from a shortage of providers, the VA facility in Anchorage contracted with Providence Alaska Medical Center, Southcentral Foundation, and Anchorage Neighborhood Health Center to provide care to veterans.¹⁴

Outside of Anchorage, the VA has community-based outpatient clinics, located at Fort Wainwright (Fairbanks), Kenai, Juneau, and Wasilla.

In fiscal year 2013, Alaska Veterans AHS received funds to develop a specific Telebehavioral Health program in partnership with Southeast Alaska Regional Health Consortium (SEARHC). Based out of Sitka, Alaska, SEARHC is a non-profit tribal health consortium of 18 Native communities which serves the health interests of the Native people of Southeast Alaska. The aim of this program is to develop and implement a telebehavioral health clinic in partnership with SEARHC, to provide VA mental health services for rural Native Veterans. The clinic uses a model of a credentialed VA provider in the VA and a system providing telebehavioral health care with a local on-site outreach worker to help with the patient site logistics.

Coast Guard Clinics

The US Coast Guard history of service in Alaska dates back to the Revenue Cutter Service. Coast Guard personnel and their families are stationed throughout Alaska, including remote sites such as Port Clarence, St. Paul, Attu, Dutch Harbor, and Shoal Cove. Coast Guard clinics in Kodiak, Juneau, Sitka,

¹¹ Alaska Population Overview, 2012 Estimates: 22,438 active duty military personnel (3.1% of state)

¹² U.S. Department of Veterans Affairs, http://www.va.gov/vetdata/Veteran_Population.asp

¹³ Joint Base Elmendorf-Richardson. "About 673 MDG." Available at <http://www.jber.af.mil/hosp/history.asp>.

¹⁴ VA partners with Anchorage health clinic for veterans' care. *Anchorage Daily News*. March 30, 2014. <http://www.adn.com/2014/03/30/3401706/alaska-va-partners-with-anchorage.html>

and Ketchikan support the health care needs of 2,500 active duty, reserve, auxiliary and civilians supporting operations in Alaska.¹⁵

Alaska Federal Health Care Partnership

Alaska Federal Health Care Partnership (AFHCP) is a voluntary partnership of the organizations serving the federal health care beneficiaries in Alaska. AFHCP combines the healthcare resources of the Alaska Native Medical Center/Alaska Native Tribal Health Consortium, Department of Defense, Department of Homeland Security, Department of Veterans Affairs, U.S. Coast Guard, and the Indian Health Service. The combined beneficiary population of these organizations is over 250,000, with some beneficiaries having dual, or even triple, eligibility within the health and wellness provider systems. An example of this collaboration is the telehealth project completed in 2007 which provided equipment and networking capability to remote areas of the state.

B. Facilities

1. Acute Care Facilities

Hospitals

There are 27 hospitals in Alaska: 24 that provide general acute care (including two military and seven tribally-operated hospitals) and three specialized hospitals (one long term acute care and two psychiatric hospitals).¹⁶ The greatest concentration of hospitals is in the Anchorage/Mat-Su region. The relatively large hospitals in Anchorage and Fairbanks serve as referral facilities for providers from rural areas of the state. Hospitals in Seattle also serve as key referral destinations for residents of Alaska in need of specialty services.

Statewide, there are 1,485 licensed beds in Alaska hospitals, not including those operated by the military. Of those beds, 190 are psychiatric in the two specialized hospitals, 60 are long term acute care, and 161 are identified as swing beds that can be used for acute or long term care.

Table 1: Alaska Hospitals, 2014¹⁷

Region/Hospital	Location	Licensed Beds**	Governance
Anchorage Matanuska-Susitna Region			
Providence Alaska Medical Center	Anchorage	326	Private Non-Profit
Alaska Regional Hospital	Anchorage	250	Private For-Profit
Alaska Native Medical Center	Anchorage	150	Tribal Health Corporation; Federal ownership
Joint Base Elmendorf-Richardson	Anchorage	110	Federal Military
Mat-Su Regional Medical Center	Palmer	74	Private Non-profit
St. Elias Long Term Acute Care Hospital	Anchorage	60	Private Non-Profit
Alaska Psychiatric Institute	Anchorage	80	Public State
North Star Hospital	Anchorage	110	Private For-Profit
Interior Region			
Fairbanks Memorial Hospital	Fairbanks	152	Private Non-Profit
Bassett Army Community Hospital	Ft. Wainwright	55	Federal Military
Southeast Region			

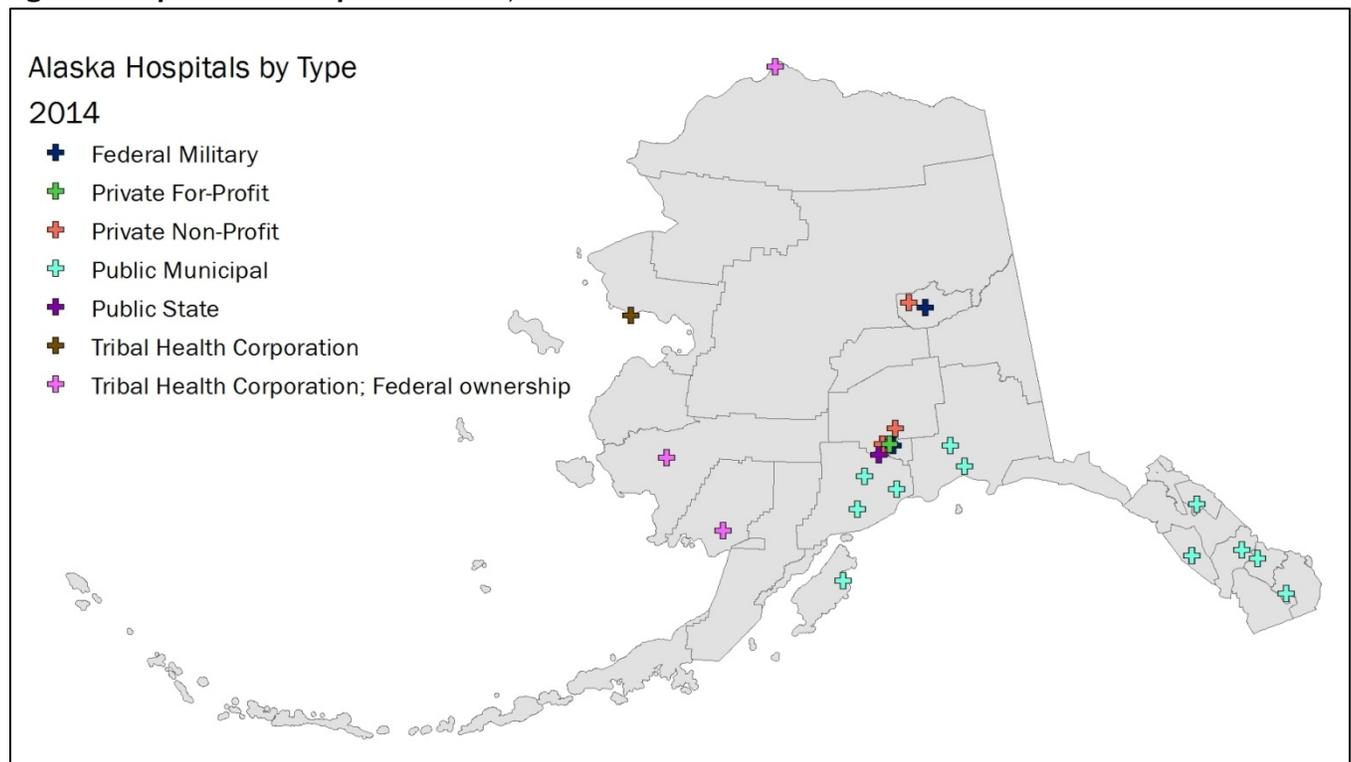
¹⁵ United States Coast Guard 17th District, <http://www.uscg.mil/d17/images/D17%20Fact%20Sheet.pdf>

¹⁶ Health Facilities Licensing Certification, Division of Health Care Services, Facility List dated 2/27/2014.

¹⁷ Health Facilities Licensing Certification, Division of Health Care Services, Facility List dated 2/27/2014.

Bartlett Regional Hospital	Juneau	73	Public Municipal
Ketchikan General Hospital*	Ketchikan	25	Public Municipal
Petersburg Medical Center*	Petersburg	12	Public Municipal
Mt Edgecumbe Hospital	Sitka	27	Tribal Health Corporation; Federal ownership
Sitka Community Hospital *	Sitka	12	Public Municipal
Wrangell Medical Center*	Wrangell	8	Public Municipal
<i>Gulf Coast Region</i>			
South Peninsula Hospital*	Homer	22	Public Municipal
Providence Kodiak Island Medical Center*	Kodiak	25	Public Municipal
Providence Seward Medical Center*	Seward	6	Public Municipal
Central Peninsula Community Hospital	Soldotna	49	Public Municipal
Providence Valdez Community Hospital *	Valdez	11	Public Municipal
Cordova Community Medical Center*	Cordova	13	Public Municipal
<i>Southwest Region</i>			
Yukon-Kuskokwim Delta Regional Hospital	Bethel	50	Tribal Health Corporation; Federal ownership
Kanakanak Hospital*	Dillingham	16	Tribal Health Corporation; Federal ownership
<i>Northern Region</i>			
Norton Sound Regional Hospital*	Nome	18	Tribal Health Corporation
Samuel Simmonds Memorial Hospital*	Barrow	14	Tribal Health Corporation; Federal ownership
Manillaq Medical Center*	Kotzebue	17	Tribal Health Corporation; Federal ownership
* Medicare-Certified Critical Access Hospital (CAH)			
** Total beds include licensed and/or certified acute care and swing beds. Hospitals may operate with fewer beds than the number licensed.			

Figure 4: Map of Alaska Hospital Locations, 2014



The scope of services provided by Alaska's urban hospitals has been changing dramatically. Bed counts have remained quite stable in the last decade, but hospital "campuses" have grown to accommodate an array of emerging technologies and day treatment services that were formerly available only as inpatient services or out-of-state. Examples of services that have been introduced by hospital systems in the last decade include: cardiac catheterization, cardiac electrophysiology ablation, cardiac rehabilitation, chemotherapy and cancer services, renal dialysis, pediatric medicine, birthing centers, outpatient surgery, sleep disorder testing, sports medicine rehabilitation, and expanded hospice and home care. The addition or expansion of these services to Alaska's urban hospitals has provided an incentive to physicians and businesses that support these services to establish residence and to provide care in Alaska, often partnering with the hospital care system. This has allowed Alaskans to receive care in-state.

Two rural hospitals recently completed renovations to expand their facilities and increase capacity. Norton Sound Regional Hospital in Nome opened its new facility in January 2013. The new facility is three times the size of the old building, and was funded in part by the Denali Commission.¹⁸ In Barrow, the project to replace the Samuel Simmonds Memorial Hospital with a new facility four times larger than the previous hospital was funded under the Title V new construction program and the Denali Commission.¹⁹

Critical Access Hospitals

Alaska's hospitals in communities with populations smaller than 30,000 – that is, outside of Anchorage, Mat-Su, Fairbanks and Juneau – are recognized to be critical "economic engines" of their communities, providing jobs directly, and providing assurance of emergency services and access to care for residents of their service areas, and for employers who want to attract workers. The Balanced Budget Act of 1997 (Public Law 105-33)²⁰ established the Medicare Rural Hospital Flexibility Program, a national program designed to assist states and rural communities in improving access to health care services in rural areas through the development of limited service hospitals and rural health networks. The program provided resources to hospitals to assess the feasibility of converting to critical access hospital designation. Thirteen Alaska hospitals (see Table 1) are certified by Medicare as Critical Access Hospitals (CAH) enabling them to obtain cost-based reimbursement rates from the Federal Medicare program.

A Critical Access Hospital (CAH) is an acute care facility that provides emergency, outpatient, and limited inpatient services and may be linked to full service hospitals and other types of providers in a rural health network. CAHs generally provide inpatient care for up to 96 hours, unless discharge or transfer is precluded due to inclement weather or other emergency conditions. CAHs may maintain up to 25 beds to furnish both acute and skilled nursing level care, provided that no more than 15 of these beds are used for acute care at any one time. A CAH may operate nursing home beds or provider-based services like home health. CAHs are reimbursed on a reasonable-cost basis for services provided to Medicare beneficiaries.

Trauma Center Designation

Alaska Native Medical Center is Alaska's only Level II trauma center. Under criteria from the American College of Surgeons, Level II trauma centers provide comprehensive trauma care, serving as the lead trauma facility for a geographical area. Emergency physicians and nurses are available in-house to

¹⁸ "Norton Sound Regional Hospital." Available at: <https://www.nortonsoundhealth.org/Locations/Norton-Sound-Regional-Hospital>.

¹⁹ "Replacement Hospital Project Overview." Available at: http://www.arcticslope.org/hospital_replacement.html.

²⁰ Available at: <http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/html/PLAW-105publ33.htm>.

provide direct patient care, initiate resuscitation, and stabilization; general surgeons and certain specialty surgeons should be available on call. A Level II trauma center also provides educational outreach and prevention programs, and assumes responsibility for trauma system leadership in the absence of a Level I Trauma Center. Alaska does not have a Level I trauma center; the nearest Level I Trauma Center is located in Seattle.

Level IV trauma centers are smaller rural facilities that provide initial evaluation of injured patients prior to transfer to other facilities.²¹ There are five Level IV trauma centers in Alaska: Norton Sound Regional Hospital (Nome), Yukon-Kuskokwim Delta Regional Hospital (Bethel), Sitka Community Hospital and Mt. Edgecumbe Hospital (Sitka), and Bartlett Regional Hospital (Juneau).

2. Outpatient Facilities

Changes in technology and medical practice have allowed patients to receive some services as outpatients rather than being hospitalized. Outpatient services can be performed in a hospital setting or in a freestanding facility. Currently the State of Alaska licenses ambulatory surgery centers and birthing centers in addition to hospitals that may offer ambulatory surgery.²² In addition, Alaska has Medicare-certified end stage renal disease facilities.

An ambulatory surgical facility provides surgery and anesthesia service, in some cases including pain management and diagnostic services, in an outpatient setting. Ambulatory surgery centers (which may be called outpatient surgery centers or same-day surgery centers when part of a hospital) perform procedures that are more intensive than those done in the average doctor's office, but not so intensive as to require a hospital stay. In order for a facility to be licensed, services must comply with the state's standards for surgical and anesthesia services in general acute care hospitals. There are also requirements, similar to hospital medical staff regulations, for physicians working in these licensed facilities. Currently there are nine licensed Ambulatory Surgery Centers in the state.

Birthing Centers are facilities which are not a hospital or in a hospital, where births are planned to occur away from the mother's residence following normal, uncomplicated pregnancy. The state has 11 licensed Birthing Centers: in Juneau, Palmer, two each in Soldotna, Wasilla and Fairbanks, and three in Anchorage.

Alaska also has Medicare certified facilities for treatment of end stage renal disease, commonly referred to as dialysis centers. Dialysis is used to provide an artificial replacement for lost kidney function; it may be used for acutely ill patients who have temporarily lost kidney function and require services for only a short time period, but is used mostly for patients who have permanently lost their kidney function and require dialysis for an indefinite period of time. The state currently has eight Medicare-certified End State Renal Disease facilities located in Anchorage, Soldotna, Fairbanks, Wasilla, and Juneau.

Other diagnostic and testing services now being established in some instances as freestanding businesses are imaging (including Magnetic Resonance Imaging and CT scan), sleep studies, and laboratories. Such entities are being called independent diagnostic testing facilities when they are not engaged in patient treatment, but perform diagnostic tests by certified non-physician personnel under physician supervision. These facilities are independent of a hospital or physician's office. The state does not license independent diagnostic testing facilities, but does monitor the credentials of staff performing tests and the proper functioning of diagnostic equipment used by the facility.

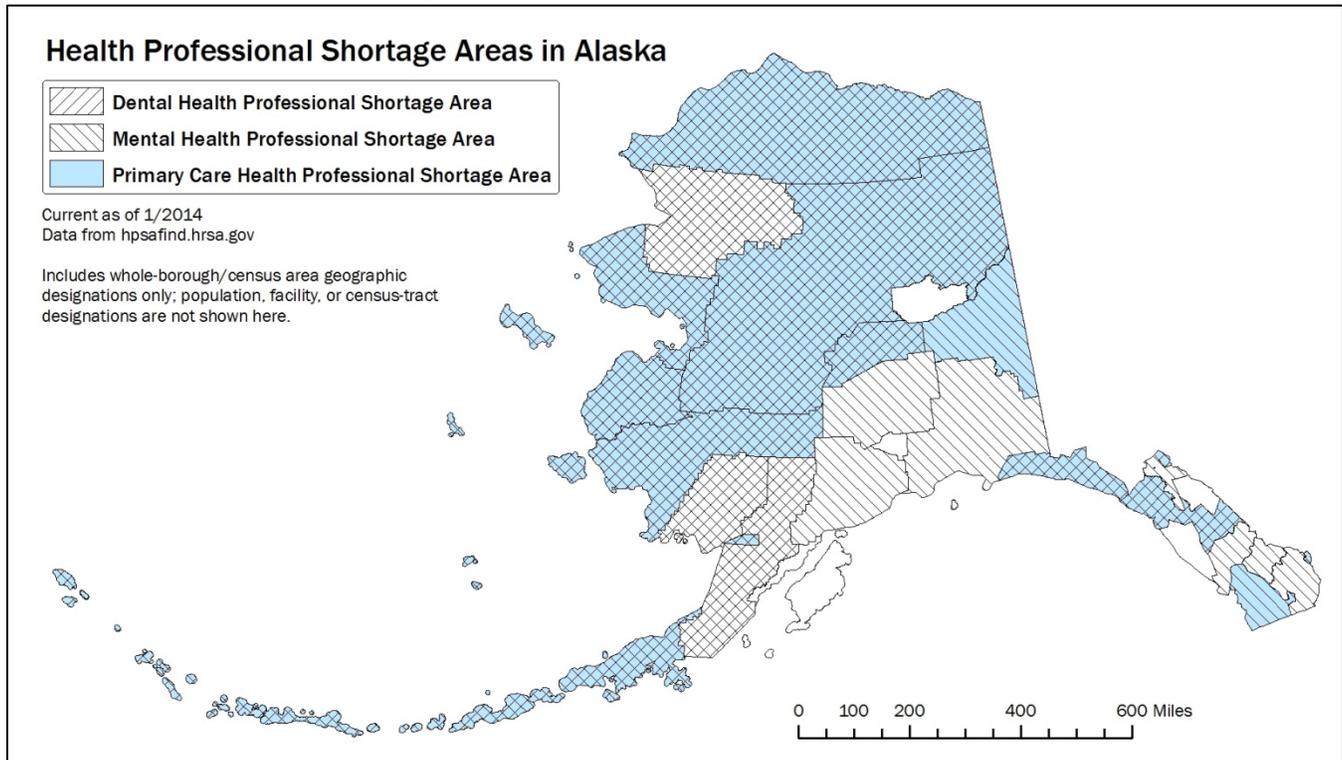
²¹ "Trauma System in Alaska." Available at: <http://dhss.alaska.gov/dph/Emergency/Pages/trauma/designation.aspx>.

²² Alaska Statute 47.32

Community Health Centers

Community Health Centers (CHCs, sometimes referred to as “Section 330 Clinics”) are non-profit, community-based organizations that provide health care to low-income and medically underserved areas and populations. The CHC program was established under Section 330 of the Public Health Services Act, and federal grant funding is provided through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). CHCs are by definition Federally Qualified Health Centers (FQHCs), which are further defined by section 1861 of the Social Security Act.²³ Tribally managed clinics may also be FQHCs.

Figure 5: Health Professional Shortage Areas, 2014



Community Health Centers along with other federal health programs are required to serve populations or be located in areas identified by the Shortage Designation Branch of the Health Resources and Services Administration. Health Professional Shortage Areas (HPSAs) are rational service areas that fall below a certain threshold for population-to-provider ratio in addition to other criteria for need. Medically Underserved Areas/Populations (MUA/MUP) are geographic areas or groups of residents who face

²³ Section 1861 of the Social Security Act "(4) The term “Federally Qualified Health Center” means an entity which: (A)(i) is receiving a grant under section 330 (other than subsection (h)) of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 (other than subsection (h)) of such Act; (B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; (C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or (D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act."

particular economic, cultural, or linguistic barriers to healthcare.²⁴

“Health care safety net” is a term used to refer to a wide variety of providers delivering care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid and Medicare. The safety net can also refer to health care providers who are required by law to see patients regardless of ability to pay, including emergency departments at public hospitals and Community Health Centers. Public Health Centers, non-profits, as well as community hospitals, private physicians, and other providers also deliver a substantial amount of care to these populations.

Community Health Centers provide all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.

Health services provided by CHCs include:

- Services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology provided by physicians, physician assistants, nurse practitioners, nurse midwives, and health aides;
- Diagnostic laboratory and radiological services;
- Preventive services, including prenatal services; screening for breast and cervical cancer; well-child services; immunizations; screenings for communicable diseases, environmental contaminants, and chronic health conditions; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; family planning services; and preventive dental services;
- After hours coverage for medical emergencies during hours when the center is closed;
- Hospital admitting privileges and continuum of care; and
- Pharmaceutical services.

Additionally, CHCs are expected to provide behavioral health care that is integrated into primary care services as well as referrals to specialty behavioral health providers when indicated. Community Health Centers provide patient case management services including counseling, referral, and follow-up services and patient education regarding health conditions and the availability and use of health services.

Community Health Centers differ from privately-run physician offices and clinics in several ways:

- They are required to have a governing board of directors that includes a majority of consumer representatives;
- They must meet significant federal requirements for an ongoing quality improvement/quality assurance program that includes clinical services and management;
- Their funding is contingent upon demonstration in their funding proposals and utilization reports that they attend to the health status of the entire community in addition to the clinic’s patient population. To that end, health centers are expected to lead community efforts to conduct regular community needs assessments and they often participate in prevention program opportunities to address such conditions as diabetes, hypertension, or chronic obesity;
- They are required to provide services regardless of the patient’s ability to pay and must offer a sliding fee discount schedule;
- Medicaid and Medicare reimbursement for CHCs is done via a Prospective Payment System (PPS), which is based on the health center’s cost of service.

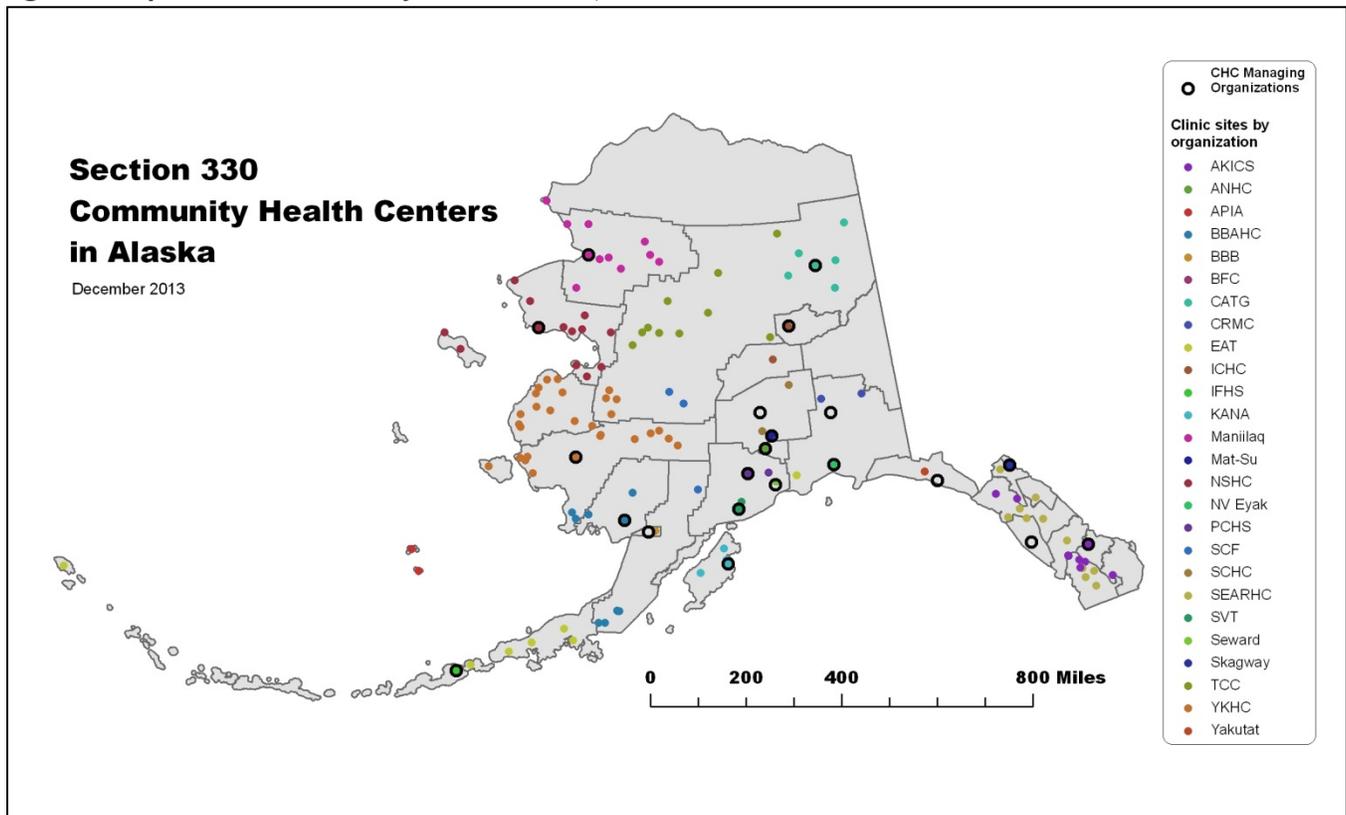
²⁴ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations.” <http://www.hrsa.gov/shortage/>. A list of current designations can be found at <http://hpsafind.hrsa.gov>.

The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care (HRSA) periodically makes U.S. Public Health Service, Section 330 funds available to CHCs to expand their scope of services. Oral health and mental health services are two of the services that have been the focus of additional funding available to CHCs. Many Alaska CHCs have taken advantage of these funding opportunities. Increasingly CHCs are co-locating or otherwise integrating the provision of general dentistry and behavioral health services into their primary care clinics.

In Alaska, between 1995 and 2014, the number of CHCs grew from two provider agencies – the Anchorage Neighborhood Health Center and Interior Neighborhood Health Center (Fairbanks) operating in four service delivery sites, to 27 provider agencies currently operating 148 service delivery sites.²⁵ HRSA continues to periodically offer such “New Access Point” funding opportunities to CHCs, allowing them to expand services to new communities.

In 2012, Alaska CHCs served 98,568 unduplicated patients, 86.2% of whom were at or below 200% of poverty level.²⁶

Figure 6: Map of Alaska Community Health Centers, 2014 ²⁷



Frontier Extended Stay Clinics

In remote frontier areas of the country weather and distance can prevent patients who experience severe

²⁵ Based on “AK CHC Clinic Sites” 4.2014 and <http://datawarehouse.hrsa.gov/HGDWReports/OneClickRptFilter.aspx?rptName=FAHCSiteList&rptFormat=PDF>
²⁶ UDS Data Warehouse. 2012 Health Center Data. Available at <http://bphc.hrsa.gov/uds/datacenter.aspx?year=2012&state=AK>.
²⁷ Data from UDS Data Warehouse and Alaska Primary Care Association.

injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of these communities providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. A three-year Centers for Medicare and Medicaid Services (CMS) demonstration project was conducted from 2010-2013 in Alaska in which four “Frontier Extended Stay Clinics” (FESCs) received enhanced payments for the extended services provided to Medicare and Medicaid patients, as Medicare-certified providers of these services. Some reimbursement was also provided by other third party payers. The FESC demonstration sites included Alicia Roberts Medical Center, Cross Road Medical Center, Haines Health Center, and Iliuliuk Family and Health Services. A final evaluation report is under review by CMS. While the CMS FESC demonstration project and enhanced payments ended in March 2013, extended services continue to be provided by the demonstration sites on a more limited basis.

Rural Health Clinics

A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement under program to improve access to primary care in underserved rural areas. RHCs must provide outpatient primary care and laboratory services, and are required to use a team approach of physicians and midlevel practitioners (such as nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50 percent of the time with a midlevel practitioner. RHCs can be for-profit or non-profit entities, and can be either publicly or privately owned and operated.

Rural Health Clinic certification was established under the Rural Health Clinics Act, passed by Congress and signed into law in 1977. The goal of this Act was twofold. First, it encouraged the utilization of mid-level providers by providing reimbursement for services to Medicare and Medicaid patients by these health professionals, even in the absence of a full-time physician. Second, it created a cost-based reimbursement mechanism for services when provided at clinics located in underserved rural areas.²⁸ In Alaska, where a majority of rural primary health care programs operate with funding from the Indian Health Services (IHS) and Section 330 Community Health Center grants from Health Resources and Services Administration (HRSA), the RHC program has not provided the same financial advantages that it has in other states. Tribally-managed clinics have more favorable reimbursement rates than Rural Health Clinics for their Medicare and Medicaid patients, and many of the tribal clinics are also under the Community Health Center program. While there have been certified RHCs in Alaska in the past, there are currently no clinics operating as RHCs in Alaska.

Physician, dentist and other professional offices

Many physicians and dentists in Alaska are practicing in solo practice offices, but many share professional office space with others or form group practice offices. Private practice offices of physicians and dentists are concentrated in Alaska’s largest communities.

Urgent care centers

Some physicians operate their office as an urgent care center or clinic. They have been established in Anchorage, Fairbanks, Juneau, Kenai, and the Matanuska-Susitna Valley. These can be operated by a single physician or group of practitioners or the center can be affiliated with a hospital based health care system. Urgent care centers are primarily used to treat patients who have an injury or illness that

²⁸ “Underserved” means that an area has too few providers to meet the needs of the population. For official designation as an “underserved” area, the area needs to be found to be a Health Professional Shortage Area (HPSA) or Medically Underserved Population or Medically Underserved Area (MUA/MUP), as defined in Federal regulations. The Alaska Primary Care Office handles designation applications to the Health Services and Resources Administration.

requires immediate care, on an unscheduled or walk-in basis, but whose condition is not serious enough to warrant a visit to a hospital emergency department. Often urgent care clinics are not open on a continuous basis, unlike a hospital emergency room, but provide extended hours compared to a primary care physician’s office. They often provide basic laboratory and imaging services, and referral is made to the appropriate health care provider for follow-up care and treatment. Urgent care centers have the same licensing requirements as that of a primary care physician’s office or practice.

Mid-level provider clinics

Mid-level providers include nurse practitioners, certified nurse midwives, and physician assistants. Clinics staffed by midlevel providers include a handful of private clinics. Clinics run by communities or tribal organizations employ mid-level providers when the community does not have a population base sufficient to support a physician practice. Mid-level clinics also include workplace clinics focusing on occupational health and urgent response for oil companies on the North Slope.

Public Health Centers

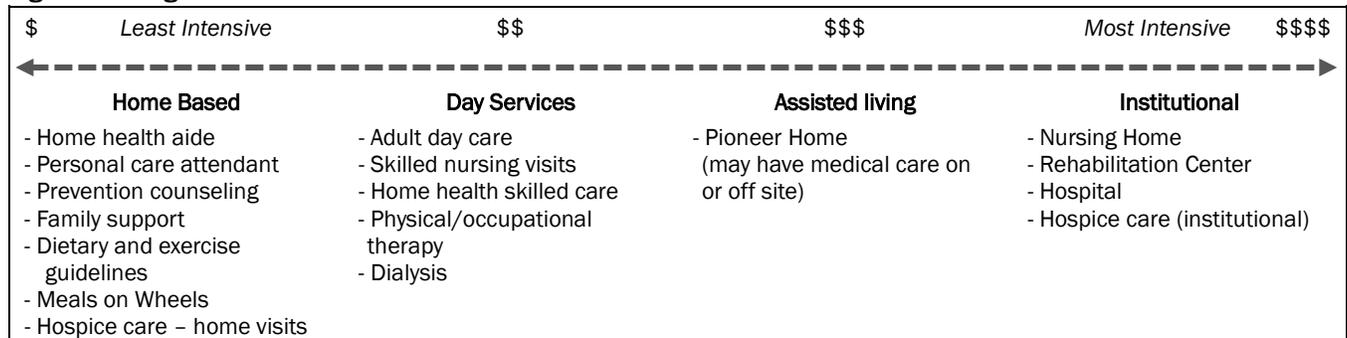
Alaska’s Public Health Nursing services are provided at Public Health Centers located throughout the state in 23 locations as well as itinerant services. Three additional agencies (Maniilaq Association, North Slope Borough, and Municipality of Anchorage) provide services with state grant assistance.²⁹ Clinic services are available to all residents on a sliding fee scale, and no one is turned away for inability to pay. Services include immunization, family planning, Early and Periodic Diagnosis and Testing, sexually transmitted diseases screening, counseling and partner follow-up, and chronic disease services, as well as health education, and community development activities.

3. Long Term Care Services and Facilities

Long term care is distinct from acute care, which focuses on curing an illness or restoring an individual to a previous state of better health. Long term care encompasses a broad range of assistance, services, and supports to meet health and personal care needs over an extended period of time, from nursing home care to home based assistance.

The primary goal of long term care services is to enable senior citizens and disabled individuals to remain in their homes or communities and includes not only health care but services necessary to maintain quality of life including such things as housing and transportation.

Figure 6: Long Term Care Continuum of Care



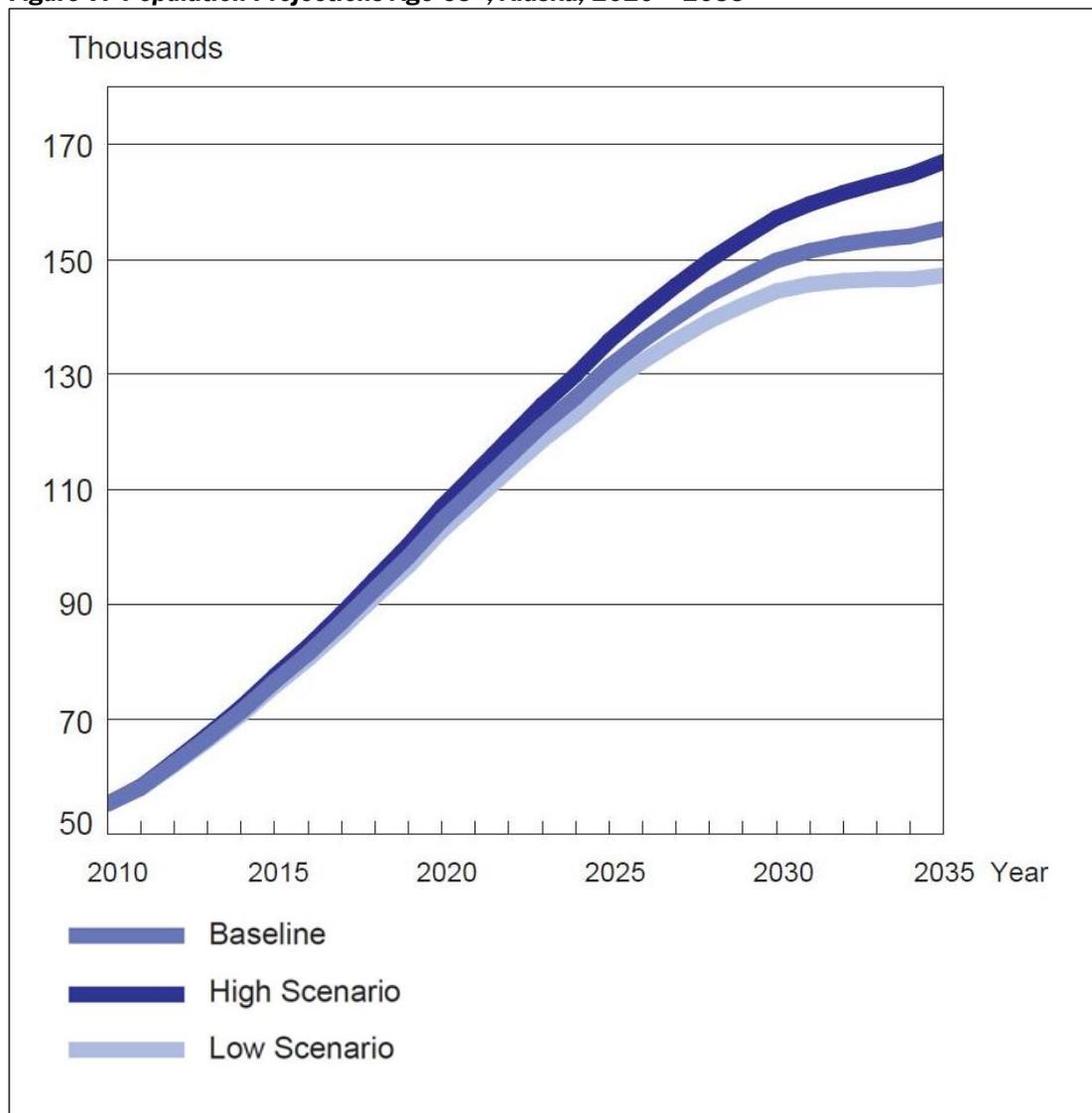
Long term care is provided in a range of settings known as a “continuum of care” depending on an individual’s needs and preference (Figure 6). Most long term care is non-skilled personal care

²⁹ “Public Health Centers.” Available at: <http://dhss.alaska.gov/dph/Nursing/Pages/locations.aspx>.

assistance, commonly referred to as custodial care, such as help performing everyday Activities of Daily Living (ADL) such as bathing and dressing, in the individual’s home. Another level of care in the patient’s home is home health care provided by skilled and licensed medical professionals. Alaska currently has 13 licensed Home Health Care agencies which provide skilled medical care to patients in their homes. Of these 13 agencies, eight are hospital based.

When a patient is terminally ill, regardless of age, hospice care can be a choice for the patient and their family. Hospice care provides support by both medical professionals and trained volunteers focusing on the palliation, or relief of symptoms, of a terminally ill patient. This support can be physical, emotional, spiritual, or social. The State currently has 10 licensed hospice agencies.³⁰

Figure 7: Population Projections Age 65+, Alaska, 2010 – 2035 ³¹



Senior housing provides living arrangements designed for physical accessibility, safety, and convenient access to services. When a senior citizen or disabled individual is no longer able to remain in his or her

³⁰ Health Facilities List, Health Facilities Licensing and Certification Section, Division of Health Care Services, 2014

³¹ Alaska Department of Labor and Workforce Development, Research and Analysis Section. (April 2012) Alaska Population Projections: 2010-2035. Available at: <http://laborstats.alaska.gov/pop/projected/pub/popproj.pdf>.

own home, or with supportive family members, other types of residential care may be available to allow the person to remain in the community.

Group homes with assistive services are called “assisted living” facilities. Alaska Pioneer Homes are assisted living homes owned and operated by the State of Alaska. The six Pioneer Homes, in Fairbanks, Palmer, Anchorage, Juneau, Sitka, and Ketchikan, have 508 beds. Assisted Living Licensing in the Division of Health Care Services lists 625 current licensed assisted living facilities with 3,644 beds (including the Pioneer Homes). Most are small; the average capacity is under six.³²

Nursing facilities or nursing homes provide intensive services for those needing a higher level of care. They offer both short and long-term placements for senior who require significant nursing interventions each day. Alaska has 17 licensed nursing facilities with 674 beds.³³ Recently, Medicare has made comprehensive information about all Medicare and Medicaid-certified nursing homes available online at “Nursing Home Compare.”³⁴

Demand for long-term care will continue to increase. According to current projections by the Alaska Department of Labor and Workforce Development, the population aged 65 and older will nearly triple over the next 20 years, from about 43,000 people in 2005 to over 150,000 in 2035.³⁵

The goal of keeping people in their homes and communities is also expressed through planning for services for individuals with developmental disabilities, to provide home and community based services where possible, for housing and support for employment.

Table 2: Number of Agencies Providing Long Term Care Services

Agencies Providing Long Term Care Services	Number
Home Health	13
Hospice	10
Pioneer Home	6
Assisted Living	619
Nursing Homes	17

4. Behavioral Health Facilities

Facilities that offer care to people with mental illness and substance abuse problems range from community clinics (least intensive services) to hospitals for acute psychiatric care (North Star is licensed for 74 beds at the 2530 DeBarr location and for 36 beds at the extension location at 1650 South Bragaw for a total of 110 beds. Alaska Psychiatric Institute has 80 beds). Additional hospitals in Juneau, Fairbanks and regional hubs provide evaluation, stabilization, and short-term treatment and referral.

Thirteen non-profit organizations receive grants to provide residential substance abuse treatment. Detoxification beds are available in Anchorage, Juneau, and Fairbanks.

Alaska has five Residential Psychiatric Treatment Centers (level 5) with a total of 183 residential

³² Division of Health Care Services (2014) “Assisted Living Licensing.” <http://dhss.alaska.gov/dhcs/Pages/cl/all/default.aspx>.

³³ Health Facilities List, Health Facilities Licensing and Certification Section, Division of Health Care Services, 2014.

³⁴ Nursing Home Compare. <http://www.medicare.gov/nursinghomecompare/search.html>.

³⁵ Alaska Department of Labor and Workforce Development, Research and Analysis Section. (April 2012) Alaska Population Projections: 2010-2035. Available at: <http://laborstats.alaska.gov/pop/projected/pub/popproj.pdf>.

psychiatric treatment center beds statewide (2014), and residential treatment in lower levels of care (levels 2, 3, and 4).

Table 3: Residential Psychiatric Treatment Facilities ³⁶

Level 5 Total	183
Fairbanks/Ester	22
Anchorage/Eagle River/Mat-Su Valley	161
Levels 2, 3, and 4 Total	659
Fairbanks/Ester	117
Anchorage/Eagle River/Mat-Su Valley	223
Kenai	15
Juneau/Ketchikan/Craig/Sitka/Wrangell	224
Barrow/Bethel/Kotzebue	80

In addition, as of a hand count in December, 2011, there are approximately 379 beds licensed by the Office of Children’s Services as foster or group homes in which youth also receive therapeutic behavioral health services. Most are located in the Anchorage Municipality and Matanuska- Susitna Borough.³⁷

In addition, there are approximately 320 beds in “Treatment Resource Homes” with behavioral health services for youth. Most are located in the Anchorage Municipality and Matanuska-Susitna Borough.

Agencies across the state receive grant funds from the Department of Health and Social Services and the Alaska Mental Health Trust Authority to assist residents with behavioral health needs and help to prevent suicide, substance abuse, and other problems. Approximately 71 organizations are receiving grants from the Department of Health and Social Services Division of Behavioral Health in FY 2014 to provide behavioral health treatment and recovery services.³⁸

By default, the Department of Corrections (DOC) has become the single largest provider of mental health care in Alaska. A 2006 study found that approximately 42 percent (1,524 of 3,628 as of June 30, 2006)³⁹ of the people incarcerated in Alaska correctional facilities were Trust beneficiaries, with mental illness, substance-related disorders and/or mental disabilities. Also many youth within the Division of Juvenile Justice system have a co-occurring disorder (substance related disorder accompanied by a mental health disorder). A current alternative to incarceration for adults with severe mental illness is diversion into Anchorage or Palmer Coordinated Resources Projects (also called therapeutic courts). Therapeutic court programs are also operating in Juneau, Ketchikan, Bethel and Fairbanks.

Integration of behavioral health and primary care has been advanced by some Section 330 Community Health Centers that have received special funding from HRSA to include services for mental health and substance abuse.

The Alaska Mental Health Trust Authority and its statutory boards, along with the Department of Health

³⁶ Data from Department of Health and Social Services, Residential Licensing.

³⁷ “Alaska Youth Behavioral Health Residential Bed Resources Updated Inventory – December 2011,” Steve Hamilton.

³⁸ Alaska Department of Health and Social Services, Division of Behavioral Health.

³⁹ *A Study of Trust Beneficiaries in the Alaska Department of Corrections*. Produced by Hornby Zeller Associates for the Alaska Department of Corrections, funded by the Alaska Mental Health Trust Authority. December 2007. Available at http://www.mhtrust.org/layouts/mhtrust/files/documents/reports_studies/DOC%20Study%20of%20Trust%20Beneficiaries%20-%20Exec%20Summary.pdf

and Social Services, develop the Comprehensive Integrated Mental Health Plan to address the needs of Trust Beneficiaries experiencing mental illness, alcoholism and substance use disorders, brain injury, developmental disabilities, and Alzheimer’s disease and related dementia. The Department and the Trust collaborate together to convene the interested parties to review and plan for population needs, facilities, workforce, and other beneficiary-related program initiatives.

5. Emergency Medical Services

Emergency Medical Services (EMS) are provided by mobile intensive care paramedics (“Paramedics”) and Emergency Medical Technicians (EMTs) licensed by the state. Programs are organized by seven regional EMS programs (including three non-profit EMS councils, three programs based in tribal health corporations, and one program by the Barrow Volunteer Fire Department) work with the community-based emergency medical services to be sure that emergency medical services personnel (EMTs) are available to respond to the emergency medical needs of Alaska’s citizens and visitors, and to be sure that the personnel and their ambulances and air transport are properly equipped. The State Division of Public Health and Alaska Council on EMS have duties to certify EMTs and work with the EMS programs on their training, reporting and assurance of adequate equipment.⁴⁰ “Medevacs” (air rescues) play a major role in Alaska.

C. Health Care Providers

Health care professionals include a variety of specialists and primary care providers in medicine, dentistry, mental health, and substance abuse services. Health care providers also include allied health professionals providing support services, alternative or complimentary providers, and para-professionals.

In recent years, concerns about current and potential shortages of health care professionals have led to several studies of supply and demand, recruitment, and retention of physicians and other health care providers in Alaska.⁴¹ The Health Workforce Coalition was formed in 2010 as a public-private partnership to address health workforce challenges in Alaska; membership includes state government, the University of Alaska, healthcare providers, employers, and professional associations. Other initiatives include the Physician Supply Task Force and the Status of Recruitment Resources and Strategies (SORRAS) I and II projects.

The Alaska Health Workforce Vacancy Studies were conducted in 2007, 2009, and most recently in 2012 by Alaska Center for Rural Health at the University of Alaska. These studies sought to answer questions on health workforce and better understand shortages and vacancies in the state.

Loan repayment programs are one example of the types of programs that aim to improve access to care by addressing shortages and distribution of health care providers. Alaska’s SHARP Program helps to recruit and retain health care professionals to serve in state-designated shortage areas in exchange for the repayment of qualifying education loans and/or payment of direct incentive through a combination of

⁴⁰ Division of Public Health. “About ACEMS.” <http://dhss.alaska.gov/dph/Emergency/Pages/acems/default.aspx>.

⁴¹ Securing an Adequate Number of Physicians for Alaska’s Needs: Alaska Physician Supply Task Force Report (August 2006) <http://www.hss.state.ak.us/commissioner/Healthplanning/publications/assets/PSTF-06.pdf>;

SORRAS I: Status of Recruitment Resources and Strategies (2004),

<http://www.hss.state.ak.us/dph/healthplanning/publications/assets/SORRASreport.pdf>;

SORRAS II: Status of Recruitment Resources and Strategies 2005–2006,

http://nursing.uaa.alaska.edu/acrh/projects/sorras_report05-06.htm; and Alaska Center for Rural Health, 2012 Alaska Health Workforce Vacancy Study, <http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/2012workforce.cfm>.

federal, state, foundation, and employer match funding. To date, 136 SHARP clinicians have provided healthcare in over 38 communities throughout the state. SHARP clinicians work in a broad range of healthcare occupations, including behavioral health, medical care, and dental care.⁴²

National Health Service Corps (NHSC) is another program in which providers can benefit from loan repayment in exchange for working in approved areas. Sites must be in Health Professional Shortage Areas and provide services regardless of patients' ability to pay. Currently Alaska has 206 NHSC approved sites. Indian Health Service also has a loan repayment program which awards up to \$20,000 per year for a two-year commitment to work in a tribal health program.⁴³

1. Primary Care and Specialty Medical Providers

Primary care services in Alaska are provided by a spectrum of providers, including primary care physicians, mid-level providers (physician assistants and nurse practitioners), and Community Health Aides and Community Health Practitioners. The state licensing database (relying on address listed by the license applicant) shows that most physicians are located in larger communities, those with at least 1,000 people. Some of the physicians and mid-level practitioners practice in Community Health Centers and Rural Health Clinics (RHCs).

Some clinics are implementing integrated care teams which may consist of a small number of physicians, nurses, pharmacists, medical assistants, behaviorists and other providers which serve a panel of patients so that care is more coordinated, consistent and patient-centered. Alaska clinics are moving toward more coordinated, comprehensive care as they work to achieve patient-centered medical home competencies.

Several of the smallest hospitals have hired physicians directly to ensure staffing, and most larger hospitals as well as the tribally managed facilities have hired physician staff members, to serve as emergency room physicians, hospitalists, or generalists who work in outpatient, inpatient and itinerant services.

Specialists are more likely to be in the largest urban areas where they can rely on access for their patients to the tertiary care hospitals (those with more advanced services), the support staff and other support services that can support their practices.

Health care provider statistics are available from multiple sources, and each has its own limitations. The Alaska Department of Commerce, Community, and Economic Development maintain a searchable professional license database.⁴⁴ Entering a licensing board type (e.g. medical, dental, social work, nursing) allows users to download a listing of current licensees. However, for a variety of reasons (retirement, leaving the State), not all licensed providers are currently practicing in the state. Licenses counted for this analysis include full, active licenses with an Alaska address, and are sorted by the licensee's given address.

Table 4a: Workforce: Licensed physicians, mid-level providers and dental providers, by region, 2014

Region	Physician (MD)	Physician (DO)	Physician Assistant	Nurse Practitioner	Dentist	Hygienist
Statewide	1688	170	490	610	559*	531

⁴² <http://dhss.alaska.gov/dph/healthplanning/pages/sharp/>

⁴³ Indian Health Service Loan Repayment Program, FAQ. <http://www.ihs.gov/loanrepayment/faq.cfm>.

⁴⁴ <http://commerce.alaska.gov/occ/OccSearch/main.cfm>

Anchorage/Mat-Su	1141	68%	113	66%	274	6%	393	4%	345	62%	338	64%
Gulf Coast	125	7%	15	9%	44	9%	58	10%	58	10%	60	11%
Interior	185	11%	24	14%	90	8%	62	10%	79	14%	66	12%
Northern	27	2%	1	1%	13	3%	11	2%	9	2%	2	0%
Southeast	179	11%	13	8%	35	7%	62	0%	52	9%	58	11%
Southwest	31	2%	4	2%	33	7%	24	4%	16	3%	7	1%
*Generalists and Specialists (34 are licensed as specialists, without a “generalist” license)												
Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2014).												

Similarly, Alaska Department of Labor and Workforce Development Occupational Database⁴⁵ tends to over-report the number of actual workers within an occupation. Data is generated by employers for each salaried worker covered by unemployment insurance. Worker counts reflect the cumulative number of salaried workers within an occupation over a specific period (quarterly and annually). Because a single salaried position may be filled by multiple people during the year, the annual count will likely exceed the number of positions. Conversely, many physicians and dentists practice in their own offices and are thus not included in “employment” counts.

Table 4b: Workforce: Employed physicians, mid-level providers and dental providers, by region, 2012

Region	Medical Doctor		Physician Assistant		Nurse Practitioner		Dentist		Hygienist	
Statewide	1617		623		326		282		453	
Anchorage/Mat-Su	758	46.88%	281	41%	228	61%	120	41%	364	63%
Gulf Coast	117	7.24%	36	5%	27	7%	17	6%	59	10%
Interior	109	6.74%	94	14%	34	9%	43	15%	72	13%
Northern	70	4.33%	88	13%	7	2%	17	6%	5	1%
Southeast	168	10.39%	61	9%	28	8%	21	7%	58	10%
Southwest	395	24.43%	128	19%	47	13%	73	25%	16	3%
Source: Alaska Department of Labor and Workforce Development, Occupational Database, http://laborstats.alaska.gov/?PAGEID=67&SUBID=212 .										

A third source of provider information, the 2012 Alaska Health Workforce Vacancy Study⁴⁶ utilized a sampling strategy to generate estimates of health provider vacancies. From a population composed of Alaska’s 500 largest employers of health workers, a sample was created using all 25 instructional institutions and a random sample from of the remaining 475 employers. Population-weighted estimates were created from data received from responding participants.

Table 4b: Workforce: Estimated total positions: physicians, mid-level providers and dental providers, by region, 2012 (includes filled and vacant positions). Estimated statewide vacancy rate 8%⁴⁷

Region	Medical Doctor	Physician Assistant	Nurse Practitioner	Dentist	Hygienist
Statewide	2369	527	911	785	619

⁴⁵ <http://live.laborstats.alaska.gov/odb/odb.cfm>

⁴⁶ Available at <http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/2012workforce.cfm>

⁴⁷ Alaska Center for Rural Health/Alaska Health Education Center. Alaska Workforce Vacancy Study (2012). <http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/2012workforce.cfm>.

Anchorage/Mat-Su	1494	63%	233	44%	532	58%	519	66%	474	77%
Gulf Coast	205	9%	20	4%	42	5%	41	5%	35	6%
Interior	345	15%	146	28%	118	13%	97	12%	41	7%
Northern	70	3%	55	10%	36	4%	30	4%	5	1%
Southeast	167	7%	16	3%	65	7%	69	9%	53	9%
Southwest	88	4%	57	11%	118	13%	29	4%	11	2%

Source: Alaska Center for Rural Health/Alaska Health Education Center. Alaska Workforce Vacancy Study (2012).
<http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/2012workforce.cfm>

Table 5: Nurses in Alaska, by type and region, 2014

Region	Registered Nurse		Practical Nurse	
Statewide	7651		742	
Anchorage/Mat-Su	4909	64%	430	58%
Gulf Coast	755	10%	77	10%
Interior	912	12%	135	18%
Northern	123	2%	24	3%
Southeast	784	10%	61	8%
Southwest	168	2%	15	2%

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2014).

Registered nurses (RNs) and licensed practical nurses (LPNs) are licensed by the state; Certified Nurse Aides and Personal Care Attendants are not licensed. It should be noted that many nurses cycle into and out of Alaska from out-of-state employment services that help to fill needs for either specialist or generalist nurses, when local supply is insufficient to meet local needs. Data on numbers of such seasonal and/or temporary nurses is not available.

Table 6: Licensed physical and occupational therapists, active and resident in Alaska, 2014

Region	Physical Therapists		Occupational Therapists	
Statewide	529		240	
Anchorage/Mat-Su	323	61%	162	68%
Gulf Coast	55	10%	24	10%
Interior	62	12%	24	10%
Northern	4	1%	0	0%
Southeast	77	15%	30	13%
Southwest	8	2%	0	0%

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2014).

Table 7: Licensed Pharmacists and Techs, 2014

Region	Pharmacist		Pharmacy Tech	
Statewide	546		1,628	
Anchorage/Mat-Su	342	63%	1062	65%
Gulf Coast	61	11%	170	10%
Interior	62	11%	154	9%
Northern	8	1%	47	3%
Southeast	56	10%	173	11%

Southwest	17	3%	22	1%
Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2014).				

546 pharmacists and 1,628 pharmacy technicians are licensed in 2014 in Alaska. The 2012 vacancy study by Alaska Center for Rural Health estimated a vacancy rate of 5% and 2% statewide, respectively.⁴⁸

2. Behavioral Health Providers

Many rural Alaska communities have either only part-time workers helping with behavioral health needs or no mental health services other than the occasional itinerant provider. The 2012 Alaska Health Workforce Vacancy Study showed that the vacancy rates for all behavioral health occupations were about 10%, and the psychiatrist vacancy rate 22% statewide.⁴⁹

To help bridge the gaps in services, the Alaska Native Tribal Health Consortium has developed a training certification program for village-based behavioral health aides (BHAs). Where possible, BHA services are integrated into primary care settings.

Behavioral health professionals with current active licenses in Alaska include 145 clinical psychologists (PhD); 494 licensed professional counselors; 80 marriage and family therapists; 633 social workers (bachelor’s and master’s level); and 39 psychological associates. Approximately 480 certified chemical dependency counselors, counselor technicians, and traditional counselors provide services throughout the state; many also have state behavioral health professional licenses. The levels and requirements for certification for the many categories of provider are summarized on the website of the Alaska Commission for Behavioral Health Certification.⁵⁰

Most of the state’s psychiatrists are in the Anchorage/Mat-Su Area. Many are in private practice, others work partially or wholly as contractors or employees within the tribal system, the military or not-for-profit service agencies. Several Alaska-based and out of state psychiatrists itinerate to regional medical centers to provide psychiatric assessments and to oversee treatment for residents. Telemedicine has become a tool for increasing access to psychiatric services with links to remote sites across the state, through the tele-behavioral health program based at the Alaska Psychiatric Institute, the telebehavioral health network based at the Alaska Native Health Consortium, and through the Department of Corrections’ links to prisons from Anchorage.

Table 8: Active Alaska resident licensed providers in behavioral health, 2014

Region	Clinical Psychologist		Licensed Professional Counselor		Marriage & Family Counselor		Clinical Social Worker (BA, MSW, LCSW)		Psych Associate	
Statewide	145		494		80		633		39	
Anchorage/Mat-Su	104	72%	295	60%	52	65%	342	54%	30	77%
Gulf Coast	11	8%	44	9%	8	10%	52	8%	3	8%
Interior	16	11%	64	13%	10	13%	89	14%	4	10%

⁴⁸ Alaska Center for Rural Health/Alaska Health Education Center. Alaska Workforce Vacancy Study (2012). <http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/2012workforce.cfm>.

⁴⁹ Alaska Center for Rural Health/Alaska Health Education Center. Alaska Workforce Vacancy Study (2012). <http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/2012workforce.cfm>.

⁵⁰ Alaska Commission for Behavioral Health Certification. http://www.akcertification.org/index.php?main_page=index&cPath=2

North	1	1%	5	1%	1	1%	22	3%	0	0%
Southeast	10	7%	69	14%	8	10%	106	17%	2	5%
Southwest	3	2%	17	3%	1	1%	22	3%	0	0%
Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2014).										

3. Allied Health Providers

Allied health professions are clinical health care professions distinct from medicine, dentistry, and nursing, but generally supporting those services in helping to meet patients' needs. Although they are an integral part of the overall delivery of care and assist in making the health care system function, there is relatively little information tracking these workers, except for the categories of workers for whom licensure is required by state law. Their salaries and other costs are generally rolled into administrative or program costs. Selected allied health occupations are listed in the following table, showing the average quarterly employment in Alaska for 2012 calendar year.

Table 9: Allied Health Employment (Average per Quarter, 2012)

Occupation	Average quarterly employment
Dental Assistant	1107
Dental Hygienist	453
Dental Lab Tech	41
EMT/ETT & Paramedic	407
Medical & Clinical Lab Technician	333
Medical & Clinical Lab Technologist	248
Medical Records Technician	497
"Other" health technician (SOC code 292099)	497
Optician	152
Optometrist	37
Pharmacy Technician	580
Psychiatric Technician	424
Physical Therapy Assistant	49
Radiologic Technician	425
Respiratory Therapist	160
Surgical Tech	171
Source: Alaska Department of Labor and Workforce Development, Occupational Database, http://laborstats.alaska.gov/?PAGEID=67&SUBID=212 ,	

4. Paraprofessionals (CHA/P, DHA, BHA)

The Community Health Aide (CHA) program was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and high rate of injuries in rural Alaska. In 1968, the CHA Program received formal recognition and congressional funding. The long history of cooperation and coordination between the federal and state governments and the tribal health organizations has facilitated improved health status in rural Alaska.

The CHA program now consists of a network of approximately 550 Community Health Aides / Practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the

2006 Alaska Community Health Aide/Practitioner Manual, which outlines assessment and treatment protocols. There is an established referral relationship, which includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps.

The Alaska Area Native Health Service is responsible for providing medical and health related services to Indian Health Service beneficiaries residing in Alaska. These services are provided by tribal organizations within the Alaska Tribal Health System. The village based CHA/Ps are a vital link in the delivery system.

Community Health Aides are selected by their communities to receive training. Training centers are located in Anchorage, Bethel, and Nome. There are four sessions of CHA training; each lasts three to four weeks. Between sessions, the CHAs work in their clinics completing a skills list and practicum. Completion of the four session training curriculum and successful completion of a clinical skills preceptorship and examination, qualify the CHA as a Community Health Practitioner (CHP). CHA/Ps at any level of training may obtain certification by the Community Health Aide Program Certification Board.

Under the direction of the Tribal Health Directors, ANTHC used the Community Health Aide program as a model to train and deploy a workforce of Behavioral Health Aides (BHAs).⁵¹ A partnership was formed between the federally recognized Community Health Aide Program Certification Board (CHAPCB) and a subcommittee of the Tribal Behavioral Health Directors, the Behavioral Health Academic Review Committee (BHARC), to amend the existing Standards and Procedures to include standards for Behavioral Health Aides/ Practitioners certification and practice.

The BHA Program is facilitated through ANTHC's Behavioral Health Department in collaboration with the BHARC. Program staff provide technical, financial, and training support to Tribal Health Organizations who have elected to integrate BHAs into their regional network of behavioral health providers. As a resource to all BHAs, the BHARC, staff from ANTHC's Behavioral Health Department and statewide team of stakeholders are developing a Behavioral Health Aide Manual (BHAM) to provide fundamental information and best-practices for addressing many of the issues and concerns identified during client care visits. The BHAM is a practice manual that compliments BHA training requirements and scope of practice that have been detailed in the Standards.

The BHA is a counselor, health educator, and advocate to help address community behavioral health needs which include alcohol, drug, and tobacco abuse and mental health problems such as grief, depression, suicide, and related issues. BHAs seek to achieve balance in the community by integrating their sensitivity to cultural needs with specialized training in behavioral health concerns and approaches to treatment.⁵² There are currently 41 certified BHAs in the state.⁵³

The Dental Health Aide (DHA) Initiative was introduced under the federally sanctioned Community Health Aide program in Alaska. These new dental team members work with tribal health dentists and hygienists to provide education, prevention and basic restorative services in a culturally appropriate manner.⁵⁴ DHAs provide evidence-based prevention programs and dental care that improve access to oral health care and help address well-documented oral health disparities.⁵⁵

⁵¹ Alaska Native Tribal Health Consortium (ANTHC) Available at <http://www.anthc.org/chs/behavioral/bha.cfm>.

⁵² Alaska Native Tribal Health Consortium (ANTHC) Available at <http://www.anthc.org/chs/behavioral/bha.cfm>.

⁵³ CHA/P Certification Board, January 2014

⁵⁴ U.S. National Library of Medicine, National Institutes of Health, available at

The DHA Initiative introduced four new dental provider types to Alaska: the Primary Dental Health Aide, the Expanded Function Dental Health Aide, the Dental Health Aide Hygienist, and the Dental Health Aide Therapist. The scope of practice between the four different DHA providers varies vastly along with the required training and education requirements. DHAs are certified, not licensed, providers. Recertification occurs every 2 years and requires the completion of 24 hours of continuing education and continual competency evaluation.⁵⁶ There are currently 69 certified DHAs in 41 communities in Alaska.⁵⁷

5. Complementary and Alternative Health Practitioners

In Alaska, licensed alternative or complementary providers are chiropractors, acupuncturists and naturopaths:

Table 10: Licensed Complementary/Alternative Providers, 2014

Region	Chiropractors		Acupuncturists		Naturopaths	
Statewide	269		95		36	
Anchorage/Mat-Su	140	52%	67	71%	18	50%
Gulf Coast	55	20%	15	16%	2	6%
Interior	33	12%	2	2%	10	28%
Northern	4	1%	0	0%	0	0%
Southeast	30	11%	11	12%	6	17%
Southwest	7	3%	0	0%	0	0%

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development, 2014

D. Health Information Technology

1. Health Information Technologies in Alaska

Health Information Exchange

Senate Bill 133, passed in the 2009 legislative session, intended to modernize Alaska’s health-care IT infrastructure by providing for development of a secure electronic Health Information Exchange (HIE) system. The intended outcome of a fully implemented Alaska Health Information Exchange Network is to improve the patients’ access to care, reduce unnecessary testing and procedures, improve patient safety and outcomes, reduce health agency administrative costs, and enhance rapid response to public health emergencies.

The Alaska eHealth Network (AeHN) is a non-profit corporation selected by the State of Alaska Department of Health and Social Services to develop and manage Alaska’s Health Information Exchange (HIE). AeHN, governed by a board of directors, is involved in the development of policies and procedures, agreements, and technical planning for HIE in Alaska. AeHN also manages the Alaska

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753165/>.

⁵⁵ U.S. National Library of Medicine, National Institutes of Health, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753165/> (Int J Circumpolar Health. 2013; 72: 10.3402/ijch.v72i0.21198. Published online Aug 5, 2013. doi: 10.3402/ijch.v72i0.21198).

⁵⁶ U.S. National Library of Medicine, National Institutes of Health, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753165/> (Int J Circumpolar Health. 2013; 72: 10.3402/ijch.v72i0.21198. Published online Aug 5, 2013. doi: 10.3402/ijch.v72i0.21198).

⁵⁷ CHA/P Certification Board, January 2014

Regional Extension Center, a federally-funded center providing assistance to providers adopting and implementing electronic health records.⁵⁸

Alaska's query-based HIE went into production in June 26, 2013 for pilot sites in Fairbanks. Two facilities are now on-boarded to the query-based HIE with another eight facilities in process; 10 clinics are using the view-only HIE access with another 30 clinics requesting view-only HIE access. Several other facilities are reviewing contracts and discussing options with their internal stakeholders.

Health Information Technology (HIT) is expected to be a means to achieve affordable, safe, and accessible health care. Digital applications available for use by health-care providers and organizations include personal health records (PHRs), electronic health records (EHRs), electronic medical records (EMRs), computerized physician order entry (CPOE) systems, and health information exchange (HIE) systems. All are governed by privacy and confidentiality regulations. Each of these refers to a different set of services:

- Personal health records are records the patient can have in his/her possession, to share with any health care provider seen, and have updated with each visit. Digital PHRs may be kept on a digital memory stick for the patient to carry. They may be self-contained or a copy of a record maintained by a provider.
- Electronic health records and electronic medical records are the mechanisms for replacing paper records with digital ones. These records are easier for doctors or other providers to “search” for medical history, prescriptions and lab results, and can be stored locally or in a remote location for electronic retrieval or for “exchange” with another provider. Although they are often used interchangeably, there is a difference between EHR and EMR. The EHR is a comprehensive, longitudinal, record of the patient's medical history or complete medical record. EMR refers to the individual pieces of the EHR such as laboratory results, electrocardiograms, prescriptions, history and physical exams, post-operative reports, radiology reports, etc.
- Computerized physician order entry (CPOE) is a process of electronic entry of medical practitioner instructions for the treatment of patients (particularly hospitalized patients) under his or her care. These orders are communicated over a computer network to the medical/nursing staff or clinical departments (pharmacy, laboratory or radiology) responsible for fulfilling the order. CPOE has the potential to decrease delays in order completion, reduce errors related to handwriting or transcription, allows order entry at the point-of-care or off-site, provides an opportunity to double check for duplicate or incorrect doses or tests, and simplifies inventory and posting of charges
- Health information exchange systems provide for electronic transfer of patient record information for various possible purposes: to store records in a central place for programs that have multiple service sites; for sending referrals or requested, approved reports between providers. Such information can be limited or comprehensive according to the permissions granted to a potential recipient based on need to know and the patient's requests and approvals.

2. Telehealth

The Alaska Federal Health Care Access Network (AFHCAN) is a telehealth system connecting more than 200 sites across the state, including Alaska Native community village clinics, sub-regional clinics,

⁵⁸ Alaska eHealth Network. “About AeHN.” Available at: <http://www.ak-ehealth.org/about-ae/>.

regional hospitals, and the Alaska Native Medical Center in Anchorage. A total of 44 federal beneficiary organizations participate in the network, including Native and tribal groups, veteran and military providers, and the state of Alaska. AFHCAN uses Telemedicine Carts in rural locations throughout Alaska to enable text, data and images to be securely sent from one provider to another.

AFHCAN initially focused on developing store-and-forward telehealth solution in response to the limited availability of broadband connectivity in Alaska, but with increased connectivity has recently expanded into utilizing broadband video conferencing for consultation. Store-and-forward telehealth still offers significant advantages due to the flexibility it affords providers to respond to cases at their convenience.

Every year, the Alaska Native Medical Center (ANMC) responds to approximately 3,000 telehealth cases and handles 66 percent of these consultations in the same day. Perhaps more impressive is that 50 percent of these cases are responded to within 60 minutes. While store-and-forward was specifically designed to enhance primary care access, approximately 25 percent of all cases today are specialty consultation requests. It has been estimated that telehealth consultations eliminated the need to travel in 75% of patients involved in specialty consultations and 25% of patients involved in primary care.⁵⁹

Department of Corrections psychiatric services unit has used video conferencing since 2000, for Anchorage-based psychiatrist and psychologist to provide follow-up and counseling to prisoners in facilities around the state.

The Alaska Psychiatric Institute (API) Tele-Behavioral Health care Services (TBHS) program was originally envisioned under the auspices of the Alaska Telehealth Advisory Council to serve rural communities in south-central and northern Alaska. The API TBHS multidisciplinary team of mental health clinicians provides behavioral health-care services to rural communities throughout Alaska by way of advanced video-teleconferencing technology. The program has continued to grow in the specific number of sites that may access psychiatry because of continuing integration with other information technology, video teleconferencing, and health-care provider networks across Alaska, including the Alaska Native Tribal Health Consortium.

The Alaska Collaborative for Telemedicine and Telehealth (AKCTT) is a statewide interagency forum working to develop a coordinated approach to telehealth in Alaska. Among the group's objectives is the uniting of all telehealth/telemedicine professionals in the State into one organization.⁶⁰

⁵⁹ Telehealth Improves Access and Quality of care for Alaskans. May 22, 2013. Agency for Healthcare Research and Quality. Available at <http://www.innovations.ahrq.gov/content.aspx?id=3932>

⁶⁰ Alaska Collaborative For Telemedicine & Telehealth (AKCTT). <http://akctt.org/>.

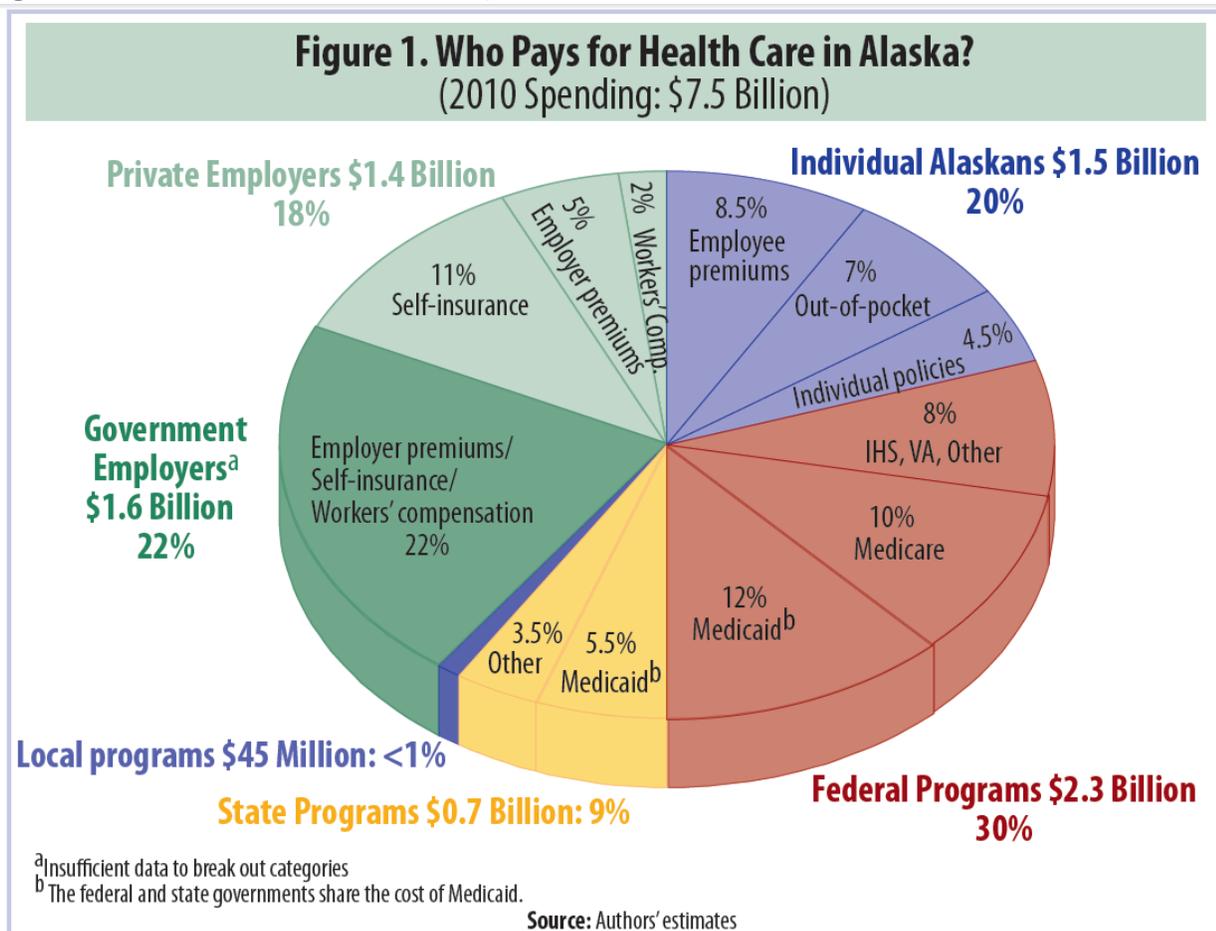
Part II. How Health Care in Alaska is Funded

A. Expenditures

The cost of health care in Alaska is shared by individuals, employers, and local, state and federal government programs. In 2010, this cost totaled \$7.5 billion.⁶¹

According to the most recent comprehensive analysis of Alaska's health spending (not including public health activities or facility construction) by the Institute of Social and Economic Research at the University of Alaska Anchorage (ISER), federal government programs, (including Medicare, IHS, VA, and a portion of Medicaid) comprise the biggest spenders at 30% (or \$2.3 billion of the \$7.5 billion total). Individuals' out-of-pocket costs, contributions to insurance premiums, and individual policies totaled \$1.5 billion, or one-fifth of total expenditures. The \$7.5 billion of health care spending in 2010 represented a 40% increase from the \$5.3 billion total reported for 2005 in the previous version of the same report.

Figure 8: Health Care Purchasers in Alaska, 2010



Reproduced from Foster, M.A. and Goldsmith, S. (2011). Alaska's Health-Care Bill: \$7.5 Billion and Climbing. *UA Research Summary 18*. Institute of Social and Economic Research, University of Alaska Anchorage.

B. Coverage

⁶¹ Foster, M. and Goldsmith, S. (2011). Alaska's Health-Care Bill: \$7.5 Billion and Climbing. *UA Research Summary 18*. Institute of Social and Economic Research, University of Alaska Anchorage.

A summary of “health care coverage” based on responses to the US Census Bureau’s annual American Community Survey shows the following types of reported coverage by insurance programs and public programs (Table 13).

Table 11: Health Insurance Coverage of Alaskans, 2010-2012 Average

	Alaska		United States
	Count	Percent of Total	Percent of Total
Covered by Any Source	559,761	79.99%	84.88%
Employer	375,515	53.66%	54.79%
Individual (self-purchased)	47,799	6.83%	12.38%
Medicaid & Denali KidCare	108,332	15.48%	17.47%
Medicare	65,607	9.37%	15.08%
Military/VA	87,030	12.44%	4.76%
Uninsured all year	140,066	20.01%	15.12%
Total	699,827	(percentages add up to more than 100 because of overlapping coverage types)	

Source: American Community Survey, three-year average, 2010 - 2012, U.S. Census Bureau.

By the Census definition, “uninsured” includes of American Indian/Alaska Native (AI/NA) people who may have access to IHS-funded services. In Alaska, this is 26% of the uninsured. It is important to note that if otherwise-uninsured American Indians and Alaska Natives are redefined as “covered,” then the estimate becomes 14% “uninsured” in Alaska. 36% of AI/AN people in Alaska have no health insurance apart from IHS benefits.^{62, 63}

Being “underinsured” (lacking insurance coverage or personal resources to pay for specific services, or being required to pay deductibles or co-payments that exceed personal resources) is a major problem to many individuals even though they have some coverage. It is also an issue for their health care providers. How many people are “underinsured” is not known. One measure is estimated by the Behavior Risk Factor Surveillance Survey, which asks respondents, “Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?” In the 2012 survey, 14.7% of Alaskans said yes.⁶⁴

1. Private Insurance

Individual policies \$348 million (2010)

Employee Premiums \$637 million (2010)

Employers Insurance premiums, self-insurance costs, and worker’s compensation \$1.3 billion

Private insurance is generally interpreted to mean both the insurance products sold to employers and employees, and to individuals, whether the employment is for a private for profit or not-for-profit firm. Individuals who pay for private insurance are likely to pay for a policy premium, and then also to pay

⁶² American Community Survey. Health Insurance Coverage Status, Table S2701.

⁶³ Tribal contract health care facilities are legally required to serve their tribal members. Other qualified American Indians/Alaska Natives may be eligible to receive care as determined by the organization. This policy makes it difficult or impossible for an American Indian or Alaska Native who leaves his tribal home for education or employment to receive the health care services to which he is legally entitled. This lack of “portability” as well as limitations in some of the services that can be provided is the basis for the Census Bureau determination not to count IHS beneficiary status as “health insurance coverage.”

⁶⁴ Alaska- IBIS. Indicator 23: Cost as a Barrier. http://ibis.dhss.alaska.gov/indicator/complete_profile/CosBarHtlhCar.html

co-payments, deductibles, and out-of-pocket costs of any services not covered by the insurance policy. The ISER estimates found that about a third of individuals' costs were for such out-of-pocket expenses.

Combining the expenditures managed by private insurance and “self-insured” (private and public) entities, and the premium payments by individuals, the ISER report estimates \$1.868 billion in expenditures for what we generally consider “employment-based health insurance.” This accounts for about 25% of health care expenditures in 2010.⁶⁵

Expenditures for “self-insured” programs include employers' contributions to such programs. In Alaska, about two thirds of all employers' (non-military) contributions are to such self-insured plans, while only one third is for “insurance premiums” in the private sector, for the insurance products regulated by the State's Division of Insurance.

2. Public insurance and coverage

Medicare – \$733 million Federal (2010)

Medicare provides coverage for health care for about 66,000 individuals in Alaska including both adults aged 65 and over and people with end stage renal disease. Medicare consists of “Part A” hospital insurance, which most participants paid into through payroll taxes while working. “Part B” medical insurance covers primarily outpatient care and physician services for participants who pay a monthly premium. Medicare prescription drug coverage is a type of insurance provided by private companies; participants choose a plan and pay a monthly premium.⁶⁶

In addition to adults aged 65 and over, Medicare also covers individuals of all ages with end-stage renal disease. Benefits include inpatient, outpatient, and home dialysis (including training, equipment and supplies, and drugs). Although dialysis facilities reimbursed must be certified by Medicare, a patient can obtain services at any approved site in the country, so travel is not restricted for individuals who need dialysis. Kidney transplant costs are also allowable, such as organ registration fees, laboratory tests for the patient and potential donors, full cost of care for donor, and immunosuppressant drugs.

Concern about Alaska physician participation in Medicare arose when a two-year special reimbursement rate for Alaska physicians (effective in 2004 and 2005, providing a differential for Alaska physicians 67% above the US average) expired in January 2006. For the three years 2006-2008, the Medicare differential for Alaska was about 5% above the US average. A new geographic differential for Alaska--29% above the US average--became effective January 1, 2009; however, even with this differential, median Medicare payments are lower than payments by private insurance, and the concern of physician non-participation continues.

Anecdotal reports of physicians refusing to accept new Medicare patients, and in some cases no longer seeing established patients, covered by Medicare emerged in the media.⁶⁷ This phenomenon was examined in a 2009 study by ISER, which found the problem to be concentrated in the urban areas of the state. In Anchorage, Mat-Su, and Fairbanks, only 35% of surveyed physicians would accept new Medicare patients; nearly all physicians in other areas of the state would see new patients under

⁶⁵ Foster, M. and Goldsmith, S. (2011). Alaska's Health-Care Bill: \$7.5 Billion and Climbing. *UA Research Summary 18*. Institute of Social and Economic Research, University of Alaska Anchorage.

⁶⁶ Medicare Program - General Information. Centers for Medicare & Medicaid Services. <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html>

⁶⁷ Alaska Medicare patients rejected by doctors. *Anchorage Daily News*. October 21, 2008. <http://www.adn.com/2008/10/21/562445/alaska-medicare-patients-rejected.html>

Medicare.⁶⁸ The survey of primary care physicians in the state found 11% of physicians had “opted out” of Medicare entirely, with an additional 4% “non-participating,” meaning that the patient is responsible for a higher portion of the cost. The remaining 85% were “participating,” though the largest numbers of these physicians were employed at Anchorage Neighborhood Health Center, a CHC, which by definition does not turn away patients. In Anchorage, such concerns led to the founding of two nonprofit Medicare-only clinics, a relatively new model of care.⁶⁹

Community Health Centers have experienced very large increases in the number of Medicare patients, from about 3,000 in 2002 to 7,000 in 2007 to nearly 9,000 in 2012.⁷⁰ Some of the increase is attributable to the addition of CHC sites throughout the state, but most of the increase is believed to have occurred in the urban clinics. Additionally, the VA clinic in Anchorage reported a near doubling of patients aged 65 and over between 2005 and 2009, suggesting that care was becoming more difficult to find elsewhere in the community for this age group.⁷¹

Medicaid – \$871 million Federal, \$409 million State (2010)

Medicaid is an entitlement program created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. The cost of Medicaid is shared by the federal and state governments. People qualify for Medicaid by meeting income and asset standards and by fitting into a specified eligibility category. Under federal rules, DHSS has authority to limit services as long as patients receive services that are adequate in “amount, duration, and scope” to satisfy the recipient’s medical needs.

Medicaid began as a program to pay for health care for poor people who were unable to work. It covered the aged, the blind, and the disabled, and single parent families. Over the years, Medicaid has expanded to cover more people. For instance, increasing income limits and removing asset limits may allow children and pregnant women to qualify for benefits. Alaska’s Medicaid expansion for these children and pregnant women is called Denali KidCare. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Many Alaskans who need but cannot afford this expensive care may qualify for Medicaid. In addition, provisions within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

Dual Eligibility (for Medicare and Medicaid)

Low-income seniors and disabled people may have “dual eligibility” for Medicare and Medicaid coverage, in which case Medicare pays first for what it covers, and Medicaid only pays for services (including beneficiary cost sharing) that are not paid by Medicare. In Alaska, Medicaid generally covers the cost of “Part B” for qualifying recipients. Part B is the part of Medicare that covers outpatient care and physician services as well as some rehabilitation services. “Part A,” which covers hospital services, is paid by Alaska Medicaid if necessary; however, most people have already paid through payroll taxes.

⁶⁸ Frazier, R. and Foster, M. (2009). How Hard is it for Alaska’s Medicare Patients to Find Family Doctors? *UA Research Summary 14*. Institute of Social and Economic Research, University of Alaska Anchorage.

⁶⁹ Anchorage Medicare clinics short of patients. *Anchorage Daily News*. January 29, 2012

⁷⁰ Health Resources and Services Administration. 2012 Health Center Data: Alaska Program Grantee Data <http://bphc.hrsa.gov/uds/datacenter.aspx?year=2012&state=AK>

⁷¹ Frazier, R. and Foster, M. (2010). *Improving Health Care Access for Older Alaskans: What are the options?* Institute of Social and Economic Research, University of Alaska Anchorage.

Indian Health Service Funds for Alaska Natives and American Indians

Alaska Natives and American Indians in Alaska from Federally recognized tribes are entitled to health care provided by Indian Health Service, in Alaska primarily through tribal contracts to provide health care services. A portion of these funds are used for “contract health services,” purchase of specialty or out of area care from non-tribal providers for beneficiaries when the services are not available through the tribal system.

TRICARE

The Department of Defense (DOD) TRICARE program (formerly CHAMPUS) is a regionally managed health coverage program for active duty and retired members of the uniformed services, their families and survivors. TRICARE is not an insurance plan, but a health care entitlement program, funded by the DOD for active duty, Guard and Reserve and retired members of the military, and their eligible family members and survivors. TRICARE for Life provides secondary health care coverage to TRICARE beneficiaries 65 years of age or older who have Medicare Parts A and B (physician and other non-inpatient care). TRICARE provides services at military treatment facilities, and supplements that with access to civilian health care networks where necessary (much like the IHS Contract Health Care program). TRICARE currently has over 89,000 beneficiaries in the state of Alaska.⁷²

3. Other types of coverage

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage. Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

Alaska Comprehensive Health Insurance Association

The Alaska Comprehensive Health Insurance Association (ACHIA) was created by the Alaska State Legislature in 1992 to provide access to health insurance coverage to all residents of the state who are unable to obtain individual health insurance due to a preexisting medical condition and who meet certain eligibility requirements. The ACHIA board has determined that the state high-risk pool will remain open through at least the end of 2014.⁷³

Fishermen's Fund

Established in 1951, the Fishermen's Fund provides for the treatment and care of Alaska licensed commercial fishermen who have been injured while fishing on shore or off shore in Alaska. Benefits from the Fund are financed from revenue received from each resident and nonresident commercial

⁷² About TRICARE: Beneficiaries by Location. Accessed 4/7/2014.

<http://www.tricare.mil/Welcome/About/Facts/BeneNumbers/States.aspx>

⁷³ <https://www.achia.com/>

fisherman's license and permit fee.⁷⁴

Denali Commission

Created by Congress in 1998, the Denali Commission, in partnership collaborative organizations, provided Federal funding for planning, designing, constructing and equipping village clinics, regional clinics and hospital clinics. Funding has been applied to primary care facilities, behavioral health centers, domestic violence shelters, elder supportive facilities, assisted living facilities, and primary care in hospitals. Congress most recently funded The Denali Commission Health Facilities Program in FY 2010. At present, no additional project proposals are being accepted.⁷⁵

Voluntary activities

Anchorage Project Access (APA) uses a volunteer network of providers to increase access to health care for low-income uninsured members of the Anchorage area. Currently, 364 physicians, 152 mid-level providers, and other support service providers participate in APA's provider network. Patients are carefully screened for income eligibility, and cannot be eligible for other programs. Between December 2005 and December 2013, 2,680 patients have been served. Over 10,044 appointments have been made on behalf of these patients.⁷⁶

Alaska Health Fairs and various periodic volunteer programs including the "Northern Edge" training program (sponsored and carried out by the military) bring additional screening, health education, and in some instances treatment services, to selected communities each year. The Mission of Mercy dental event⁷⁷ in Anchorage provided free dental care, including cleanings, fillings, root canals, extractions, x-rays, and oral health education to those unable to afford treatment, using a mobile dental clinic model used in other states.

Health Facilities and the "Certificate of Need" Requirement

The Certificate of Need (CON) program established in statute AS 18.07 is intended to promote the rational planning of health care facilities and health care services, improve citizen access to and choice of health care facility services, review the availability of qualified human resources to staff facilities and provide services, contain the costs to the state for health care facility services paid for by public funds, and avoid the proliferation of unneeded health care facilities and services in the state through the application of approved standards, review of the needs and activities of an area, and considering input from residents.

The certificate of need requirements of AS 18.07 apply to the following health care facilities licensed under AS 47.32:

- an acute care hospital;
- a critical access hospital;
- an ambulatory surgical center;
- an intermediate care facility for the mentally retarded;
- a nursing facility;
- a psychiatric hospital;

⁷⁴ Fisherman's Fund. <http://labor.state.ak.us/wc/ffund.htm>.

⁷⁵ Denali Commission. <https://www.denali.gov/>.

⁷⁶ Anchorage Project Access. www.anchorageprojectaccess.org.

⁷⁷ Alaska Mission of Mercy. <http://akmom.org/>.

- a residential psychiatric treatment center.⁷⁸

The CON requirements also apply to certain health care facilities that are not licensed under AS 47.32, independent diagnostic testing facilities and kidney dialysis centers. For facilities other than nursing homes and residential psychiatric treatment centers, the process is required if costs will exceed a certain threshold.

⁷⁸ Certificate of Need (CON) Program Summary. <http://dhss.alaska.gov/dhcs/Pages/CertificateOfNeed/default.aspx>.