

# ALASKA RURAL HEALTH PLAN

## Alaska's Plan for Participating in the Medicare Rural Hospital Flexibility Program

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# ALASKA RURAL HEALTH PLAN

## Alaska's Plan for Participating in the Medicare Rural Hospital Flexibility Program

### I. INTRODUCTION

#### **A. Purpose of the Plan**

The Balanced Budget Act of 1997 (Public Law 105-33) established the Medicare Rural Hospital Flexibility Program, a national program designed to assist states and rural communities in improving access to essential health care services through the establishment of limited service hospitals and rural health networks. The program creates the Critical Access Hospital (CAH) as a limited service hospital eligible for Medicare certification and reimbursement and supports the development of rural health networks consisting of CAHs, acute care hospitals, and other health care providers.

In response to the requirements of the program statute and regulations, the State of Alaska published this Rural Health Plan in 1998 to guide implementation of the Medicare Rural Hospital Flexibility Program. This Plan provides for the creation of rural health networks, supports the stabilization of small, rural hospitals, promotes accessibility and quality of health care services for rural residents, strengthens rural emergency medical services, and establishes the process for designating rural not-for-profit and public hospitals as CAHs. The Plan was developed after a comprehensive review of the health care system in Alaska, including analysis of existing State and Federal law, regulation, policy, and programs. The Plan was created with the input and participation of a large number of organizations and individuals, including the Alaska State Hospital and Nursing Home Association, rural hospitals located in the State, and the Alaska Center for Rural Health, the State's designated Office of Rural Health (a complete list of organizations that were consulted in development of the plan is provided in Appendix A).

The plan was revised in 2001 to provide a framework for evaluation of the first year of the rural Hospital Flexibility Program.

#### **B. State Profile**

##### **1. Geography**

Descriptions of Alaska's geography invariably begin by declaring that Alaska is the largest state in the nation. This simple declaration, however, is inadequate to effectively depict the vastness of the State's geography and the extremes of its terrain and climate. Alaska is unusual in many aspects, from its size to its climate to the differences in lifestyle and living conditions between its metropolitan areas and its smallest most remote villages. As a result, the citizens of Alaska face special and uncommon circumstances in building, maintaining, and accessing a health care

system that must serve such an expansive and diverse territory.

Alaska *is*, by far, the largest state in the nation, accounting for 20 percent of the land mass of the continental United States and encompassing an area larger than the states of Texas, Montana, and California combined. At its widest points, it stretches 2,400 miles from east to west and over 1,400 miles from north to south. If a map of Alaska is overlaid on a map of the continental United States, Alaska stretches across the country, extending from south of California to South Carolina and from North Dakota to Texas (Figure I).

**Figure I: Alaska and the Lower 48**



Alaska is home to some of the most varied and formidable terrain in the world, ranging from rainforests in the southeast to treeless tundra in the Arctic. The State has more miles of coastline than the lower 48 states combined and thousands of residents inhabit islands that can be reached only by water or air. Even Juneau, the State's capital and third largest city, is not connected to the mainland by roads and is reachable only by boat or aircraft.

Despite its size, Alaska ranks 47th among the 50 states in road miles and over 75 percent of Alaska communities are not connected by road to a community with a hospital. Extreme weather, including snow, ice, and temperatures that can reach 70 degrees below zero, makes travel very difficult in much of the state during parts of the year.

## **2. Demographics**

### Population

Alaska's population growth of 14% in between 1990 and 2000 was slightly higher than the US as a whole, but it represented a slowdown from earlier decades. The U.S. Census Bureau reports that Alaska is home to 626,932 people, ranking 48<sup>th</sup> out of the 50 states in population in 2000. Indeed, the many definitions of "rural" and even the federal definition of "frontier" -- an area of less than six people per square mile -- are inappropriately dense classifications to describe most of Alaska. Although close to half of Alaska's population is concentrated in the Anchorage region, the State's largest metropolitan area, 25 percent of all Alaskans, and 46 percent of Native Alaskans, live in communities of less than 1,000 people.

### Age

Alaska's population is aging, but it remains younger than the nation's population as a whole, and far younger than the population of most rural areas of the country. The median age of Alaskans increased by three years to 32.4 in 2000. Only six percent of Alaska's population is age 65 and over, compared to 12 percent nationwide. Thirty percent of the population is under 18. The state's relatively young population produces a different set of health system development issues and service requirements than those encountered in most rural regions of the country, creating greater needs for such services as maternal and child health and accentuating the relative dominance of Medicaid, as opposed to Medicare, as a major payer of health care services.

### Race and Ethnicity

Another of Alaska's unique demographic features is the high proportion of indigenous peoples in the population. Native Americans make up less than one percent of the population of the U.S. but comprise 16 percent of Alaska's population. Three of every four residents in the northern region of the state are Alaska Natives. Alaska Natives comprise over 60 percent of the population in southwestern Alaska. These large populations of Alaska Natives, many of whom live in small remote villages, and the complexity of federal laws addressing this population, are fundamental considerations in developing sustainable health care delivery and financing systems in Alaska.

After Alaskan Natives, Asians and African Americans are the most predominant minority racial groups, although they each make up less than five percent of the population. Five percent of Alaskans identified themselves as multi-racial in the 2000 census. Seventy three percent of the population is White. Four percent of the population say they are of Hispanic ethnicity (may be of any race group).

## **3. Economy and Income**

Oil and natural gas companies continue to be important to the Alaska economy, contributing 18% of the gross state produce in 1999. Health care and the service industry (including tourism) are now major employers, along with the military and state and federal government. Alaska

unemployment, while higher than the US average, has decreased in recent years. Unemployment rates do not reflect rural residents who are no longer actively seeking work due to the lack of opportunities in their villages.

Alaska employment is highly seasonal. Fishing and tourism, in particular, tend to depend on transient workers, creating heavy demands on local health systems during parts of the year. A delivery system, which may be adequate for the year-round resident population, can be heavily stressed by the influx of large numbers of workers and travelers during fishing or tourist season.

Alaska per capita personal income, the most widely utilized measure of the economic health of the regional economy, is now 102% of the US average.<sup>1</sup> Median household income, at \$52,869 in year 2000 inflation-adjusted dollars, is the third highest in the nation, behind New Jersey and Connecticut. The high cost of living in Alaska reduces the buying power of these relatively high incomes. Nine percent of Alaskans lived below the national poverty line in 2000, compared to 12.5% of all Americans.<sup>2</sup>

These favorable economic statistics obscure the extent of poverty in some rural areas of the state. The Denali Commission, a special federal/state commission charged with economic development of rural Alaska, has classified 194 communities as “distressed”. Distressed communities have per capita market incomes less than or equal to 67% of the US average, a poverty rate 150% or more of the US average rate, and a three year unemployment rate 150% or greater than the US rate.<sup>3</sup>

#### **4. Health Status**

The health status of Alaskans is characterized by high rates of external causes of deaths (violent deaths due to injuries, suicide, and homicide), rates of tobacco and alcohol use that are higher than the national average, a relatively high incidence of infectious diseases, and dramatic disparities in health between Alaska Natives and other Alaskans. Nonetheless, Alaska does well on some traditional measures of health status. Alaska consistently has one of the lowest rates of low birth weight deliveries in the nation, and an infant mortality rate and teen birth rate lower than the national rate. Mortality due to coronary heart disease is lower than the US rate.<sup>4</sup>

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<sup>1</sup> Alaska Department of Labor and Workforce Development. *Alaska Economic Trends*. August, 2000.

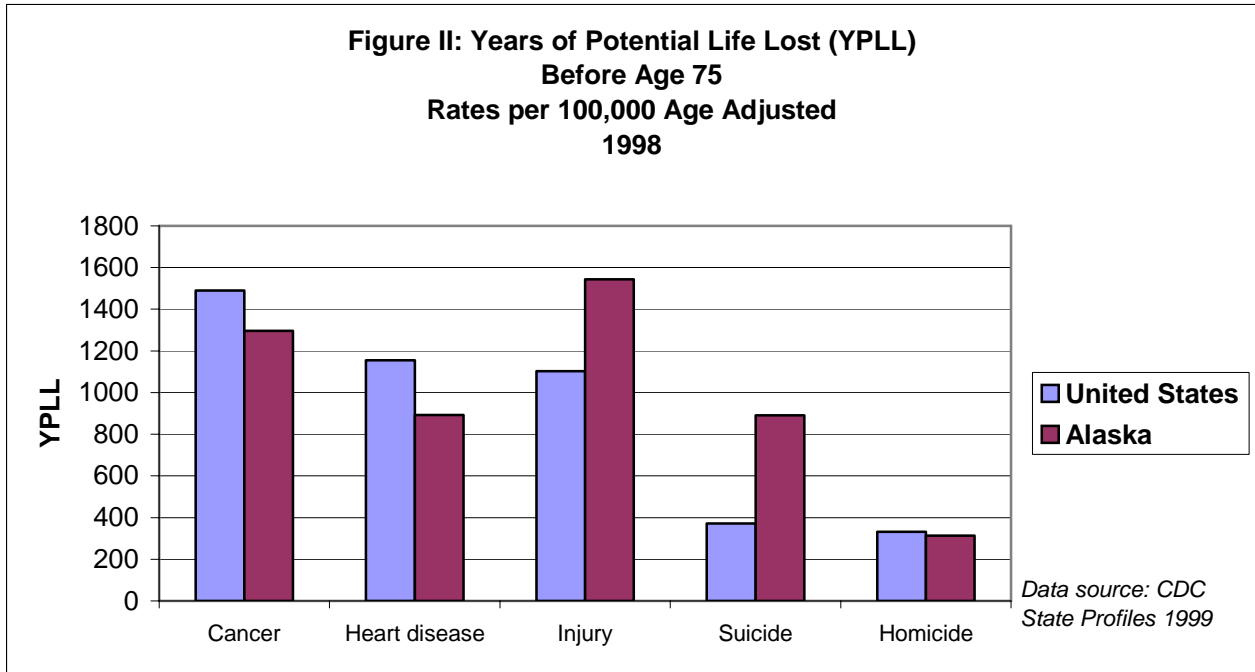
<sup>2</sup> US Census 2000: Supplementary Survey.

[http://factfinder.census.gov/servlet/QTTable?ds\\_name=ACS\\_C2SS\\_EST\\_G00\\_&geo\\_id=04000US02&q\\_r\\_name=ACS\\_C2SS\\_EST\\_G00\\_QT03](http://factfinder.census.gov/servlet/QTTable?ds_name=ACS_C2SS_EST_G00_&geo_id=04000US02&q_r_name=ACS_C2SS_EST_G00_QT03)

<sup>3</sup> Denali Commission. Distressed Community Criteria and Surrogate Standard. <http://www.denali.gov/>

<sup>4</sup> Alaska Department of Health and Social Services, Division of Public Health, Data & Evaluation. Health Status in Alaska. January, 2001.





The death rate from unintentional injuries declined by 34% during the 1990s, but remain the third leading cause of death in Alaska. The occupational injury death rate in Alaska remains the highest in the nation, despite decreasing mortality rates in commercial fishing and logging industries.<sup>5</sup> Alaska's suicide rate, the second highest in the nation, is more than twice the national rate. Injuries and suicides are major causes of Years of Potential Life Lost (YPLL) in Alaska (Figure II).

Infectious disease continues to be a problem in Alaska, despite childhood immunization rates that are comparable to the rest of the nation. Major outbreaks of measles occurred in 1996 and 1998. Alaska's tuberculosis rate in 2000 was the highest in the nation.

Disparities in health status between Alaska Natives and the population as a whole continue to be a major concern in the state. Alaska Native health improved during the 1990's on many major indicators, including overall mortality, infant mortality, unintentional injuries, and homicide mortality, but significant gaps remained for all these indicators. The suicide mortality rate among Alaska Natives actually rose during the decade, as did lung cancer and stroke mortality. Tuberculosis incidence was unchanged, and the percent of Alaska Native women receiving adequate prenatal care decreased from 57% to 50%.<sup>6</sup>

<sup>5</sup> Centers for Disease Control. Fatal occupational injuries - United States, 1980-1997. *MMWR* 50(16):317-320. April 27, 2001.

<sup>6</sup> Division of Public Health, Alaska Department of Health and Social Services. Health status disparities in selected indicators – Alaska Natives vs. All Alaskans, 1990s. February, 2001.

## **C. Profile of Alaska Health Care**

### **1. Overview**

In most parts of the country, the highest costs of delivering health care services are found in urban areas. This does not hold true in Alaska, where rural residents face higher costs than those in the state's major population centers.

Travel to rural hospitals and health care providers is expensive. Airfare to the nearest hospital may cost \$100 to \$200 per person, while travel from the more remote villages to Anchorage may cost \$1,200. Surface transportation and lodging adds to the cost of care. Many patients, such as children and elders, need caregivers to travel with them, increasing the costs. Pregnant women usually travel to a community with a hospital weeks before their due date to avoid the risks of an unattended delivery.

Services are financed by a variety of payers, including the U.S. Indian Health Service (IHS), the U.S. Departments of Defense (DoD), Veterans' Affairs (VA), Medicare, Medicaid, individuals, businesses, and private insurers. The impact of the federal government is substantial, as over 70 percent of the population receives some federally funded health care. Through IHS, DoD, VA, Medicare, Medicaid, and other programs, the federal government is the largest single payer for health care services, accounting for over a third of all dollars spent on health care in Alaska. Public expenditures, from Federal, State, and local government sources, account for more than 60 percent of Alaska's health care spending.

In 1998, 17.3% of the Alaska population was uninsured.<sup>7</sup>

### **2. Levels of Community**

The organization of health care services in Alaska depends on a community's access to the road system and distance to the nearest hospital, as well as population size and local health care resources. Services that may be regionalized in the rest of the United States have to be planned with a variety of unique concerns in mind. If the community is on the road system, is access limited by weather or seasonal changes? Is there access by water or by snowmobile trail? What kind of aircraft can land at the nearest landing strip? Are there large seasonal changes in population due to tourism, fishing, or industry?

State health planners and Emergency Medical Services developed the "Levels of Community" framework for health care services planning in the late 1970's. Each community is assigned a level based on size, geographic location, and access factors (Table I).

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<sup>7</sup> HCFA. Medicare and Medicaid Statistical Supplements for 1996 and 1999.

**Table I. Levels of Community for Alaska Health Planning**

<b>COMMUNITY TYPE</b>	<b>POPULATION</b>	<b>Health Resources</b>	<b>GENERAL ACCESS</b>
<b>LEVEL I</b>			
<b>Isolated Village</b>	Usually 50 - 1,000 in immediate community	Community clinic with a CHA* or EMT	Limited air or marine highway access to a Level III or higher community; or road access that exceeds 60 miles
<b>Highway Village</b>	Usually 50 - 1,000 in immediate community	Community clinic with a CHA* or EMT	Limited air or marine highway access to a Level III or higher community; year-round, 60 minute or less road access
<b>LEVEL II</b>			
<b>Isolated Sub-Regional Center or Town</b>	Usually 500 – 3000+ in immediate community	Community clinic with a PA, NP, MD or DO; health care services provided by public or private sector	Marine highway or daily air access to closest Level III or higher community; air service to Level I communities in area
<b>Highway Sub-Regional Center or Town</b>	Usually 500 - 3,000+ in immediate community	Community clinic with a PA, NP, MD or DO; health care services provided by public or private sector	Marine highway or daily air access to closest Level III or higher community; year-round 60 minute or less road access
<b>LEVEL III</b>			
<b>Large Town or Regional Center</b>	Usually 2,000 - 10,000+ in immediate community, providing services to a regional population	Community hospital and physicians; health care service agencies include both public and private	Daily airline service to Level III, IV & V communities; air service to Level I & II communities in area; road or marine highway access all year
<b>LEVEL IV</b>			
<b>Small City</b>	Usually 10,000 - 100,000 in immediate community, providing services to a larger regional population	Hospitals with a 24 hour staffed ED and full continuum of care; multiple providers of health care and other services including both public and private programs	Daily airline service to Level II, III, IV & V communities; road or marine access all year
<b>LEVEL V</b>			
<b>Urban Center</b>	Usually 100,000+ in immediate community providing services to a statewide population	Some specialized medical and rehabilitation services for low incidence problems	Daily airline service to Level II, III, IV & V communities; road or marine access all year
<b>OTHER AREAS</b>			
<b>Very small communities</b>	25 - 150 in immediate community	Designated area for equipment and patient care with a CHA, ETT or EMT	Limited road, air or marine highway access to a Level III or higher community
<b>Major Highways</b>	Variable	Level II ambulance service every 100 miles & first responder service every 50 miles	Year-round, 60 minute or less ground transportation or air access to a level III or higher community

<b>Marine Highway</b>	Variable	Safety officer with ETT or EMT training	Helicopter or fixed wing access
<b>At-Risk Sites</b>			
<b>Schools</b>	Variable	Safety coordinator & at least two ETTs	Air, marine & ground transportation service
<b>High-Risk Work Sites</b>	Variable	ETT or EMT for every 25 employees	More than one hour from a medical service
<b>High-Risk Work Sites: Nearby</b>	Variable	ETT or EMT for every 50 employees	One hour or less from a medical service

\* Community Health Aide

### 3. Federal Government-Owned or Funded Services

#### Services for Alaskan Natives/ Native Americans

As part of its trust responsibility, the federal government is required to provide health care services to the Native Alaskan population. The Alaska Area Native Health Service works in conjunction with nine tribally operated service units to provide comprehensive health services to 120,000 Alaska Native people. Federally recognized Alaska tribes administer 99% of the Indian Health Service earmarked for Alaska through the provision of 20 Title I contracts, 26 grants, and one compact with 20 Title V annual funding agreements.

The Alaska Native Medical Center (ANMC), a 156- bed facility in Anchorage, serves as the referral center and gatekeeper for specialty care. Tribally administered hospitals are located in the six rural communities of Barrow, Bethel, Dillingham, Kotzebue, and Nome. There are 24 tribal health centers and 176 community health aide clinics operated throughout the state.

The Alaska Native Tribal Health Consortium (ANTHC) is a statewide non-profit health services organization owned by Alaska Natives and managed by all tribes in Alaska. ANTHC was founded in 1997, and manages all statewide health services formerly provided by the Indian Health Service through a self-governance agreement, the Alaska Tribal Health Compact. ANTHC has responsibility for essential statewide services and ANMC in conjunction with Southcentral Foundation, the local Anchorage tribal health corporation for purposes of P.L. 93-638. Other federal agencies such as the Arctic Investigations Laboratory of the Centers for Disease Control (CDC), work closely with the IHS Area Office and the tribes to improve the health status of Alaska Natives.

Services available in the Alaska Native health system range from sophisticated high-tech inpatient and trauma care at the Alaska Native Medical Center in Anchorage to basic personal care services provided by Community Health Aides and Practitioners (CHA/Ps) in remote villages. CHA/Ps work under remote physician supervision in small villages throughout the state to provide primary care, prevention, and health promotion services. These providers are unique to Alaska and have no direct counterparts in the non-Native system. A full range of other services, including Community Health Clinics (CHCs), community mental health services, and hospitals are available under the Alaska Native Health System (some of these services are supported by State and private funding in addition to federal funding). Despite this breadth of

services, the Director of the Indian Health Service recently acknowledged that the tribal health programs are funded at only a fraction of the level needed to provide comprehensive care.<sup>8</sup>

#### Services for Military Personnel and Veterans

Almost a quarter of the Alaska population is eligible for health care services through the Department of Defense and the Department of Veterans' Affairs. Through these two agencies, military personnel, dependents, and retirees are provided a range of services through ten federal health facilities, including two hospitals. The military also contracts with a network of private and other providers to deliver services to eligible beneficiaries.

#### **4. Primary Care and Physician Services**

Primary care services in Alaska are provided by a spectrum of providers, ranging from Community Health Aides in remote Native villages, to mid-level practitioners in CHCs and Rural Health Clinics (RHCs), to physicians in urban multi-specialty group practices. A variety of government agencies and organizations supports the development of primary care services, including the Department of Health and Social Services, the Denali Commission, the Alaska Primary Care Office, the Alaska Primary Care Association, the Alaska Center for Rural Health, and the Alaska Family Practice Residency Program. Increasingly, more rural hospitals in Alaska are employing physicians and operating primary care clinics in conjunction with other community health services.

As in many rural areas of the country, Alaska has an inadequate supply of primary care practitioners and those that are available are disproportionately located in urban communities, especially Anchorage. Recruitment and retention is difficult in remote areas. Turnover of health personnel is an ongoing problem. Many communities rely on the National Health Service Corps for placement of physicians and other primary care providers. Itinerant Public Health Nurses play an important primary and preventive care role, particularly in the most isolated villages.

In 1998, Alaska ranked 48<sup>th</sup> among the states in the ratio of doctors to residents. Only Idaho and Oklahoma had fewer doctors per 100,000 people. The Alaska Center for Rural Health identified shortages of nurses, social workers, dentists, dental assistants, pharmacists, opticians, speech pathologists, school psychologists, physical therapists, emergency medical technicians, mental health counselors, medical transcriptionists, radiologists, respiratory therapists, community health aides, and certified nursing assistants in a November 2000 survey.<sup>9</sup> Alaska wages are no longer high enough to attract qualified workers from other states, and educational programs within the state are not adequate to meet Alaska needs. Many regions are designated Health Professional Shortage Areas (Appendix B).

In some cases, RHCs and other primary care clinics must retain patients overnight. This is often

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<sup>8</sup> Alaska Native Tribal Health Consortium. Nation's top Indian Health Service official says agency is underfunded. *Mukluk Telegraph*. 4(4), July/August 2001.

<sup>9</sup> Alaska Center for Rural Health. Alaska's allied workforce: A statewide assessment. University of Alaska Anchorage, 2001.

due to severe weather or other conditions that prevent travel and transfer but is also due to the desire to provide the patient with appropriate health care close to home and family. These facilities and attending practitioners cannot be reimbursed for providing this care, as third party payers have no mechanism for paying for “inpatient” services in these outpatient facilities (e.g., federal law precludes Medicare and Medicaid payment for overnight stays in RHCs and clinics). In many cases these clinics currently lack adequate staffing and physical plant to accommodate routine overnight patient stays. For these reasons as well as a desire to develop more local health service capacity, there is interest among the larger communities in converting clinics to CAHs.

## **5. Hospitals**

There are 24 acute care hospitals in Alaska, including two military hospitals and seven hospitals operated by tribal health corporations (Table II). The relatively large hospitals in Anchorage and Fairbanks serve as regional 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 high tech and specialty services.

With 202 hospital beds per 100,000 population in 1998, Alaska fell far below the national average of 311. Community hospital beds per capita declined 11% from 1980 to 1997, less than the national decline of 29%.<sup>10</sup> Like hospitals in the rest of the country, Alaska’s hospitals face rising costs, increases in outpatient visits, and declining inpatient utilization. Occupancy rates fluctuate, but often average 30% or less of the licensed beds. Some hospitals struggle with the problem of seasonal fluctuations in census. Shortages of health care workers, especially nurses, make it difficult to provide care for times of higher census or acuity.

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<sup>10</sup> Bureau of Health Professions. *HRSA State Health Workforce Profiles: Alaska*. 1999. Available on-line at <http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm>

**Table II: Alaska Hospitals, 2001**

<b>Region/Hospital</b>	<b>Location</b>	<b>Total Licens ed Beds*</b>	<b>Governance</b>
<b>Anchorage Matanuska Region</b>			
Providence Alaska Medical Center	Anchorage	303	Private Non-Profit
Alaska Regional Hospital	Anchorage	238	Private For-Profit
Alaska Native Medical Center	Anchorage	156	Tribal Health Corporation
Air Force Medical Center – Elmendorf AFB	Anchorage	105	Federal Military
Valley Hospital	Palmer	36	Private Non-profit
<b>Interior Region</b>			
Fairbanks Memorial Hospital	Fairbanks	162	Private Non-Profit
Basset Community Army Hospital	Ft. Wainwright	55	Federal Military
<b>Southeast Region</b>			
Bartlett Regional Hospital	Juneau	55	Public Municipal
Ketchikan General Hospital	Ketchikan	92	Public Municipal
Petersburg Medical Center	Petersburg	27	Public Municipal
Mt Edgecumbe Hospital	Sitka	60	Tribal Health Corporation
Sitka Community Hospital	Sitka	25	Public Municipal
Wrangell Medical Center	Wrangell	22	Public Municipal
<b>Gulf Coast Region</b>			
South Peninsula Hospital	Homer	47	Public Municipal
Providence Kodiak Island Medical Center	Kodiak	44	Public Municipal
Providence Seward Medical Center	Seward	6	Public Municipal
Central Penninsula Community Hospital	Soldotna	62	Public Municipal
Valdez Community Hospital	Valdez	15	Public Municipal
<b>Southwest Region</b>			
Cordova Community Medical Center	Cordova	22	Public Municipal
Yukon-Kuskokwim Delta Regional Hospital	Bethel	50	Tribal Health Corporation
Kanakanack Hospital	Dillingham	15	Tribal Health Corporation
<b>Northern Region</b>			
Norton Sound Regional Hospital	Nome	34	Tribal Health Corporation
Simmonds Memorial Hospital	Barrow	14	Tribal Health Corporation
Maniliaq Medical Center	Kotzebue	17	Tribal Health Corporation

\* Total beds includes licensed and/or certified acute care and swing beds. Many hospitals are operating with fewer beds than the number licensed.

*Data Source: Alaska Division of Medical Assistance,  
Health Facilities Licensing and Certification  
August 1, 2001*

## **6. Emergency Medical Services (EMS) System**

As noted above, injuries are the third leading cause of death in Alaska. Coupled with the State's

geography and climate and the vast distances between communities, a coordinated EMS system that links emergency personnel and other providers at all levels of the health care system is essential. Alaska's EMS system has been built over the last 30 years and has evolved from a few communities with poorly equipped and inadequately trained personnel to a system that includes both volunteer and paid first responders, trained and certified EMTs and paramedics, ground and air ambulance services, and 24-hour hospital emergency departments staffed by physicians, nurses, and other personnel trained in emergency and trauma care.

Over 3,500 EMTs, EMS Instructors, and Emergency Medical Dispatchers are certified by the Department of Health and Social Services and another 250 Mobile Intensive Care Paramedics are licensed through the Department of Commerce and Economic Development, Alaska State Medical Board. Many of these personnel are members of the approximately 150 EMS agencies and nearly 20 air medical services. Ground and air medical services providing advanced life support must be certified by the Department of Health and Social Services. Services range in size from small rural agencies providing basic life support to state of the art, paramedic-based agencies in the more populous areas of the State.

The State is divided into seven EMS regions. System goals for State, regional, and community EMS programs are set around 15 core components, including training, communications, patient transport/transfer, equipment and supplies, accessibility to care, prevention, education, and safety, and disaster response.

The lead agency in the State for the development of EMS and trauma care services is the Community Health and Emergency Medical Services (CHEMS) Section of the Division of Public Health, Department of Health and Social Services. Responsibilities of this agency include overall system coordination, injury prevention education, training and certification, and Medevac and trauma system planning. CHEMS is advised by the Alaska Council on Emergency Medical Services and has facilitated the development of the *Alaska EMS Goals*, which is used by State, regional, and local agencies for EMS planning and evaluation. The State also maintains a Trauma Registry to track the incidence, causes and severity of injuries and the quality of the trauma care provided and is developing a statewide data collection system for ground and air ambulance services.

Additional information on the state's EMS system can be found on the CHEMS web site at <http://www.chems.alaska.gov>.

## **7. Public Health Services**

As in other states, the mission of the Public Health system in Alaska focuses on health protection and promotion, disease prevention, and assuring access to quality services. To achieve this mission, Public Health services are population-based and address clinical prevention, health education, chronic and communicable diseases, maternal and child health, food and drug safety, environmental health, early intervention, mental health, substance abuse, services for the developmentally disabled, and other key health issues.

The public health system in Alaska is unique in several respects. First, public health in Alaska is



almost entirely a state responsibility. Except for the city of Anchorage and the North Slope Borough, there are no local or borough public health departments.<sup>11</sup> The Division of Public Health in the Alaska Department of Health and Social Services is responsible for both the financing and the provision of public health services throughout most of the state. Native regional health corporations in Northwest Arctic Borough and North Slope Borough contract with the State DHSS to provide selected local public health services (public health nursing and certain disease reporting and surveillance services).

Second, due to the isolation of many villages and the lack of health care providers and infrastructure, the public health system represents the main point of access to health care or social services for much of the population. As a result, Public Health Nurses (PHNs), including itinerant PHNs that travel to remote villages, are often the primary mid-level providers available to residents of these villages. The itinerant PHNs are the only health care providers for some communities. The multiple needs of the population require each PHN to carry out a variety of roles that are usually carried out by multiple people representing multiple professions in urban-based systems. It is not unusual, for example, for a PHN in a small village to provide well child care, EPSDT screening, immunizations, infectious disease prevention, education, and treatment, family planning services, coordination of care for children with special needs, home visits for at-risk families, community advocacy and organization, and other services related to health care, social, and community needs.

With the assistance of a Turning Point grant from the Robert Wood Johnson and W.K. Kellogg Foundations, the Division of Public Health is engaged in a process to assess and redesign the State's Public Health system to better meet future needs. The Alaska Public Health Improvement Process implementation plan identified development of a public health information system as its highest priority goal. The Division of Public Health and several community partners as well as the Department of Environmental Conservation are participating in the ongoing Turning Point program of national collaboratives on performance management and public health statute modernization. These activities are integrated with the state's version of Healthy People 2010 statewide planning for health status improvement.

*Healthy Alaskans 2010* ([www.hss.state.ak.us/dph/deu/projects/healthy/healthy.html](http://www.hss.state.ak.us/dph/deu/projects/healthy/healthy.html))

will be used over the decade to track changes in health status of Alaskans and to serve as a point of reference for health policy development. Using the framework of the national Healthy People 2010 document, the third decennial set of health related goals and objectives for the nation, it reflects Alaskan's priorities and objectives for improving health status, modifying exposures to health risks, and strengthening health care services, environmental and occupational conditions. The goals and objectives set in this process will be the groundwork for further policy making and for further discussion of roles, responsibilities and strategies for improving health. The Healthy Alaskans Partnership Council has the charge to identify strategies for mobilizing statewide and community action to address goals for improved health.

## **8. Other Services and Programs**

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<sup>11</sup> The two communities with local health powers have received state funds to support some their local public health services; in recent years they have been selective about what public health services they will provide.

A variety of other health care services and programs are available to residents of Alaska, including mental health, substance abuse, and long-term care services. In addition, services for special populations, such as the developmentally disabled and victims of domestic violence and sexual assault, are important components of the health care and social services system. More information on these services is available from the Department of Health and Social Services at <http://www.state.ak.us/local/akdir1.html#dhss>.

## **9. Economic Impact of the Health System on Rural Communities in Alaska**

As in the rest of the United States, the health care system in Alaska is a key component of the State's economy, generating jobs and income, encouraging new business formation and expansion, and attracting new residents. Over 18,000 people work in the health care industry in Alaska,<sup>12</sup> making it one of the State's largest employers. Health service employment grew 48% between 1988 and 1998, a per capita growth of 30%.<sup>13</sup>

In many cases these health care providers are the largest or second largest employers in their communities. Providence is Anchorage's largest private sector employer, but other examples include the Norton Sound Health Corporation (Nome), Banner Health Systems (Fairbanks), Bristol Bay Health Corporation (Dillingham), Valley Hospital (Palmer), and the Yukon Kuskokwim Health Corporation (Bethel). That these health care providers play such important roles is not surprising, given the around the clock and labor-intensive nature of their business.

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<sup>12</sup> Alaska Department of Labor. Alaska Statewide Industry Employment Estimates, 2001.

<sup>13</sup> Bureau of Health Professions. *HRSA State Health Workforce Profiles: Alaska*. 1999. Available on-line at <http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm>

## II. ALASKA RURAL HOSPITAL FLEXIBILITY PROGRAM

### **A. Program Background and Description**

The Balanced Budget Act of 1997 (Public Law 105-33) 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 creates the Critical Access Hospital (CAH), a new type of provider eligible for Medicare reimbursement. A 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.

The Medicare Rural Hospital Flexibility Program combines features of the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program and the Montana Medical Assistance Facility (MAF) Demonstration, two limited service rural hospital programs that have been operating in eight states over the past several years. The Medicare Rural Hospital Flexibility Program replaces these two programs and all states are eligible to participate. The program is administered at the federal level by the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration (HCFA)), which published regulations implementing the program October 1, 1998.

Rural not-for-profit or public hospitals are eligible to convert to CAHs, which may contain up to 15 acute care beds. CAHs provide inpatient care for up to 96 hours, unless discharge or transfer is precluded due to inclement weather or other emergency conditions or the Peer Review Organization, upon request, authorizes a longer stay.<sup>14</sup> CAHs are permitted to participate in the swing bed program and 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 also operate distinct part units (e.g., distinct part Skilled Nursing Facility) and other provider-based services (e.g., home health agency) and be co-located with other providers (e.g., a co-located nursing home).

CAHs are subject to distance requirements (i.e., a CAH must be more than a 35-mile drive, or 15 miles in mountainous terrain or areas with only secondary roads, from a hospital) or must be designated by the State as “necessary providers” of health care services to residents of the area. A CAH must make available 24-hour emergency care but need not meet all the staffing and service requirements that apply to full service hospitals. For example, some ancillary and support services may be provided on a part-time off-site basis. Inpatient care in a CAH may be provided by a mid-level practitioner (Physician Assistant or Nurse Practitioner) under the remote supervision of a physician. CAHs are reimbursed on a reasonable cost basis for services provided to Medicare beneficiaries.

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<sup>14</sup> Only existing, Medicare-certified hospitals are eligible to participate in the Medicare Rural Hospital Flexibility Program (i.e., hospitals that are closed or other types of providers are not eligible for conversion).

CAHs, full service hospitals, and other health care providers may be organized into “rural health networks,” and maintain agreements for the referral and transfer of patients, the development and use of communications systems, and the provision of emergency and non-emergency transportation services. A CAH that is a member of a rural health network must also have an agreement for credentialing and quality assurance with a hospital that is a member of the network or a Peer Review Organization (PRO) or other appropriate entity.<sup>15</sup>

## **B. Process of Developing the Alaska Rural Health Plan and the Alaska Rural Hospital Flexibility Program**

The process of developing the Medicare Rural Hospital Flexibility Program in Alaska and creating the Rural Health Plan was spearheaded by two agencies within the Alaska Department of Health and Social Services -- the Division of Medical Assistance, Health Facilities Licensing and Certification Section, the state agency responsible for certification of CAHs, and the Division of Public Health, Section of Community Health and Emergency Medical Services, the state agency responsible for administering the program. A number of other agencies, organizations, and individuals were consulted during development of the Plan. A complete list of participants is provided in Appendix A of the Plan.

With the assistance of a consultant, officials from Health Facilities Licensing and Certification and Community Health and Emergency Medical Services held frequent meetings with representatives of various groups, either in person or by telephone, to discuss issues such as plan and program requirements, regulatory concerns, the process of CAH designation and licensure, reimbursement, and other program and policy matters. These meetings were instrumental in keeping interested parties involved in the process, identifying questions and concerns, and crafting solutions to problems. In addition to these formal communications, participants and interested parties were frequently in contact informally, as well. Several of these groups also reviewed drafts of the Rural Health Plan and program policies and procedures and provided comments and feedback on these documents.

To ensure ongoing program monitoring and evaluation, a Program Advisory Committee was formed to provide program guidance and advice to Health Facilities Licensing and Certification as the program is implemented. This Advisory Committee consists of representatives of the Alaska Department of Health and Social Services, the Alaska State Hospital and Nursing Home Association, the Alaska Center for Rural Health, individual hospitals, and others. The group meets quarterly, or more frequently if necessary, to assure an ongoing collaborative effort and to address issues and problems that may arise.

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<sup>15</sup> The program statute defines a “rural health network” as an organization consisting of at least one facility that the State has designated or plans to designate as a CAH and at least one hospital that furnishes acute care services. While required to maintain certain agreements, therefore, these networks do not necessarily operate under common governance, provide integrated services, or meet other criteria that are often associated with “health networks.”

## **C. Purpose and Goals of the Program**

The Medicare Rural Hospital Flexibility Program has been instrumental in fulfilling a number of health care policy goals in the State of Alaska, including those required by the federal legislation and those that are more specific to the needs of the State. Purposes for development of the program in Alaska included:

### **1. Improve Access to Hospital and Other Health Care Services**

Like similar hospitals across the country, some of Alaska's small rural hospitals face financial difficulties and will be forced to cut back services or close their doors if present utilization and reimbursement trends continue. Some of these hospitals also face ongoing difficulties in recruitment and retention of physicians and other personnel, further threatening their ability to meet hospital licensure and certification requirements. As these facilities are often remotely located and are important providers of health care services to broad regions of the State, their survival is critical to maintaining access to health care services for some of Alaska's most vulnerable communities.

The Medicare Rural Hospital Flexibility Program has provided these hospitals with access to enhanced, cost-based funding through the Medicare and Medicaid Programs. It has also provided the hospitals and their communities with assistance to conduct assessments of community needs in respect to health services, improve health planning at the local level, and improve hospital performance and quality.

### **2. Enhance Rural Health Network Development and Regional Delivery Systems**

Because of the great distances between communities and the small number of specialty providers and secondary and tertiary level hospitals in the State, health care providers in Alaska have traditionally maintained regional networks of care, particularly for transfer and transportation of patients. In an environment where referral of a patient to another provider may entail a transfer of 1,000 miles or more in less than ideal travel conditions, effective network relationships are a necessity. In addition, mirroring health care market trends taking place in the rest of the country, large systems, including those operated by Native Corporations, have begun to seek out relationships with smaller providers in more isolated parts of the State.

The Medicare Rural Hospital Flexibility Program builds on these existing and developing affiliations by formalizing network relationships, particularly between hospitals that convert to CAHs and larger, more specialized providers. As discussed further below, the State of Alaska strongly supports network development and encourages all CAHs to join networks and maintain formal relationships with hospitals and other providers for patient referral and transfer, development and use of communications systems, provision of emergency and non-emergency transportation, and quality assurance and credentialing services. In addition, the Plan goes beyond the federal criteria and requires that CAHs that are staffed by mid-level practitioners maintain a formal network affiliation with at least one hospital. At this time,

none of Alaska's CAHs have chosen to downsize or staff solely with mid-level practitioners.

### 3. Establish and Maintain Consultative Relationships

As described above, the Alaska Department of Health and Social Services sought the input of a large number of organizations and individuals in the development of this Plan. In addition to required collaboration with the Alaska Hospital and Nursing Home Association, rural hospitals, and the Alaska Center for Rural Health, the Alaska Primary Care Association, other provider groups, regulators, communities, quality assurance advocates, and federal representatives were consulted. The RHFP Advisory Committee, which has ongoing responsibility for program monitoring and guidance provides a foundation upon which to maintain the positive relationships which have been created through the Plan development process and continue to address the health care issues faced by Alaska's rural communities and providers.

### 4. Designate Rural Not-for-Profit and Public Hospitals as CAHs

As part of the process of developing the Rural Hospital Flexibility Program, the State takes an active role in examining the characteristics of small rural hospitals and designating CAHs that can meet the requirements of the program and that are located in communities that will benefit from conversion. As detailed later in the Plan, the State conducted a "formal" designation process, which required interested hospitals to submit sufficient information to allow Health Facilities Licensing and Certification to make an informed decision on the suitability of the hospital for the program and the facility's readiness for a licensure/certification survey. The State provided information and technical assistance to interested hospitals and that the Alaska Hospitals and Nursing Home Association. Rural hospitals themselves had substantial input and involvement in the designation process.

### 5. Establish Criteria for Certification of "Necessary Providers of Health Care Services"

To be eligible for conversion to a CAH, the federal legislation authorizing the Rural Hospital Flexibility Program requires that a rural not-for-profit or public hospital is more than a 35-mile drive (or in the case of mountainous terrain, or in areas with only secondary roads, a 15-mile drive) from a hospital or is certified by the State as being a "necessary provider of health care services" to residents of the area. Unlike hospitals in many other states, every non-federal rural hospital in Alaska is at least 35 miles from another non-federal hospital (Table III).

In only a single instance are two rural hospitals closer than 35 miles -- Sitka General Hospital in Sitka is about two miles from Mt. Edgecumbe Hospital/S'axt'Hit, a facility owned and operated by the Southeast Alaska Regional Health Consortium (SEARHC). SEARHC is a Native Corporation formed to provide hospital and other health care services to Alaska Natives in the southeastern part of the State. Like other Native Health Corporations in the State, SEARHC receives federal (e.g., Indian Health Service) and other funding to carry out its mission. Provision of services at SEARHC Mt. Edgecumbe

Hospital/S'axt'Hit is generally limited to Alaska Natives and American Indians.

As a result, the State believes it is not essential to develop alternative criteria to define "necessary providers." To ensure that all rural hospitals that are essential points of access for portions of the population are clearly eligible for participation in the program, the State has developed "necessary provider" criteria that considers factors other than driving distance to another hospital to define eligibility.

**Table III: Distances Between Rural Alaska Hospitals**

		Nearest Hospital	Distance		Distance to Anchorage	
			Air Miles	Road Miles	Air Miles	Road Miles
Central Peninsula	Soldotna	Seward	-	90	-	150
Cordova Community MC	Cordova	Valdez	50	no road	160	no road
Kanakanack Hospital*	Dillingham	Anchorage	330	no road	330	no road
Ketchikan General	Ketchikan	Wrangell	75	no road	775	no road
Maniilaq MC	Kotzebue	Nome	220	no road	600	no road
Norton Sound Regional	Nome	Kotzebue	220	no road	540	no road
Petersburg MC	Petersburg	Wrangell	40	no road	670	no road
Providence Kodiak Island MC	Kodiak	Anchorage	260	no road	260	no road
Providence Seward MC	Seward	Soldotna	-	90	-	152
Simmonds Memorial H.	Barrow	Fairbanks	600	no road	752	no road
Sitka Community	Sitka	Juneau	95	no road	590	no road
South Peninsula	Homer	Soldotna	-	70	150	226
Valdez Community	Valdez	Cordova	50	no road	120	301
West Valley Medical Campus	Wasilla	Anchorage	-	43	-	43
Wrangell Medical Center	Wrangell	Petersburg	40	no road	700	no road
Yukon-Kuskokwim Regional*	Bethel	Anchorage	400	no road	400	no road

\*Dillingham and Bethel are approximately 160 air miles apart, but there is no scheduled air service and no direct water route between these communities.

## 6. Other Considerations

The Medicare Rural Hospital Flexibility Program has other positive impacts on the provision of health care services in the State. These effects result either directly from the participation in the program by small rural hospitals or indirectly through factors such as linkages established between providers or problems that are identified and solved as a result of the collaborative process of program development and monitoring. These impacts include:

- a. Improved integration of health care services between network partners and within regions.
- b. Enhanced emergency medical services through planning and network development.
- c. Ongoing monitoring and evaluation of the Medicare Rural Hospital Flexibility Program and the health care system.
- d. Enhanced ability to identify issues and address policy and legislation related to rural

- health.
- e. Enhanced understanding of the effect of policy and reimbursement decisions on small, rural hospitals.
  - f. Enhanced communications between hospital administrators and chief financial officers, clinic administrators, Medicaid reimbursement policy makers, state health facility surveyors, and public health managers.
  - g. Increased support for rural health care providers.

## **D. Critical Access Hospital Designation Process**

### **1. Overview**

Conversion to a CAH under the Medicare Rural Hospital Flexibility Program requires that a hospital first be designated and then licensed by the State and certified by the federal government. The licensure and certification process for CAHs is essentially the same as the process for licensure and certification of other types of providers -- upon request from the provider, an on-site survey is conducted by Health Facilities Licensing and Certification staff to determine whether the facility meets applicable State and Federal law and regulations. If these requirements are met, the facility is licensed and certified to provide health care services (the State licenses health care facilities under its own authority and is delegated responsibility by the federal government to determine consistency with federal rules). The Medicare Rural Hospital Flexibility Program requires an additional step in this regulatory process -- "designation" by the State that the hospital is eligible to participate in the program and convert to a CAH.

This section of the Rural Health Plan summarizes the designation process and criteria for designation. Additional description is available in Appendix E, to be updated periodically.

### **2. Identification of Interested Hospitals**

Alaska's experience is that all small, rural hospitals showed interested in analyzing the potential financial effect of conversion to a CAH, once the program was established. Several hospitals experiencing low inpatient volume in relation to licensed beds also showed interest.

### **3. Application for CAH Designation**

A hospital that wishes to be designated as a CAH is required to submit an application to Health Facilities Licensing and Certification. Application forms are provided to hospitals that have expressed interest in CAH conversion, either formally (e.g., submission of a letter of intent) or informally (e.g., a telephone call). The application form is available at [http://health.hss.state.ak.us/dma/hflc\\_cah.htm](http://health.hss.state.ak.us/dma/hflc_cah.htm).

### **4. Certification as a Necessary Provider of Health Care Services**

The federal legislation authorizing the Rural Hospital Flexibility Program requires that a CAH be more than a 35-mile drive (or in the case of mountainous terrain, or in areas with only secondary



roads, a 15-mile drive) from a hospital or be certified by the State as a “necessary provider of health care services” to residents of the area. This provision of the law is intended to limit participation in the program to hospitals that are essential points of access to a community or to parts of a community that are unable to readily access services at other facilities. The State of Alaska agrees that the focus of the program should be on hospitals that meet health care needs that cannot be easily met by other facilities due to distance and/or other factors. The State will certify a hospital as a “Necessary Provider of Health Care Services” if it meets the following criterion:

The hospital is less than a 35-mile drive (or in the case of mountainous terrain, or in areas with only secondary roads, a 15-mile drive) from another hospital, unless the nearest hospital provides services only to a certain population group or subgroup and does not routinely provide services to all members of the community. Examples of such hospitals may include facilities owned and operated by Native Health Corporations, the Indian Health Service, the U.S. military, or the U.S. Department of Veterans’ Affairs.

## **5. Network Development**

The State of Alaska strongly supports the intent of the Program to foster network development. While all rural hospitals in Alaska participate in networks at least informally, the State believes that formal membership in a network will be critical for all CAHs. As a result, network membership is mandated for these CAHs, as detailed above.

## **6. Progress**

As of fall 2001, four rural hospitals were designated as CAHs. Six others were engaged in the process of analyzing the potential effects of conversion. The two remaining candidate hospitals have indicated an interest in receiving technical assistance and funding to conduct analyses of the potential effects of conversion. Appendix C includes a map of current and potential CAHs in Alaska. Some of Alaska’s larger and better-equipped rural health clinics are considering CAH conversion. Many of these sub-regional clinics are already staffed with mid-level providers, offer emergency services around the clock, and receive regular visits from a supervising physician. Some maintain an inpatient bed, and others keep patients overnight or longer when transfer to another facility is not possible. Clinics in Metlakatla, Unalaska, Talkeetna, McGrath, Galena, Klawock/Craig, and Haines (see map in Appendix D) have these characteristics. The physical plant requirements for certification as a hospital are the main barrier to conversion for these clinics.

### **III. RELATED DOCUMENTS**

Code of Federal Regulations

Title 42, Volume 3, Parts 430 to end

Revised October 1, 1998

Conditions of Participation: Critical Access Hospitals

<http://ruralhealth.hrsa.gov/CFR-flex.htm>

Alaska Department of Health and Social Services, Division of Medical Assistance,  
Health Facilities Licensing and Certification.

Federal Acute Care, Rural Primary Care, and Critical Access Hospital Licensure

7 AAC 12.100 [http://health.hss.state.ak.us/dma/hflc\\_regulations.htm](http://health.hss.state.ak.us/dma/hflc_regulations.htm)

Critical Access Hospital Application: FFY 2001 [http://health.hss.state.ak.us/dma/hflc\\_cah.htm](http://health.hss.state.ak.us/dma/hflc_cah.htm)

## Sources

Alaska Department of Health & Social Services, Alaska EMS Goals: A Guide for Developing Alaska's Emergency Medical Services System, Fourth Edition, Section of Emergency Medical Services, Division of Public Health, February 1996.

Alaska Department of Health & Social Services, General Acute Care & Rural Primary Care Hospital Regulation, Register 142, Health Facilities Licensing and Certification, Division of Medical Assistance, July 1997.

Alaska Department of Health and Social Services. Healthy Alaskans 2010: Targets for improved health. Executive Summary. Data and Evaluation Unit, Division of Public Health, December, 2001.

Alaska Department of Health and Social Services. Health Status in Alaska: 2000 Edition. Data and Evaluation Unit, Division of Public Health, January, 2001.

Alaska Department of Health & Social Services, Listing of Licensed and/or Certified Health Facilities, Health Facilities Licensing and Certification, Division of Medical Assistance, August 1, 2001.

Alaska Department of Health & Social Services, Primary Care Cooperative Agreement: Base Grant, Primary Care and Health Promotion Unit, Section of Community Health and Emergency Medical Services, Division of Public Health, 1998.

Alaska Department of Health & Social Services, Alaska Public Health Improvement Process: Traveling the Road to a New Century in Public Health, Division of Public Health, March 1997.

Alaska Department of Health & Social Services, Trauma Triage, Transport & Transfer Guidelines, Section of Emergency Medical Services, Division of Public Health, August 1995.

Alaska Native Tribal Health Consortium. Strategic Plan: 2000- 2005. July, 2000.

Alaska State Legislature, Health Resources and Access Task Force, Final Report to the Governor and Legislature, January 1993. Alaska Statutes, Volume 5, Title 16 to Title 20, Alaska Legislative Council, Charlottesville, Virginia: Michie Law Publishers, 1996.

Balanced Budget Act of 1997 (Public Law 105-33), August 5, 1997.

Centers for Disease Control. Alaska 2001: State Health Profile. Atlanta: US Department of Health and Human Services, 2000.

Limited-Service Rural Hospital Program, Medical Rural Hospital Flexibility Program Final Regulations, Federal Register, May 12, 1998.

## **Appendix A**

### **Participants in the Rural Health Plan Development Process**

#### Alaska State Hospital and Nursing Home Association Hospitals :

- Alaska Native Medical Center, Anchorage
- Bartlett Regional Hospital, Juneau
- Cordova Community Medical Center, Cordova
- Ketchikan General Hospital, Ketchikan
- Norton Sound Regional Hospital, Nome
- Petersburg Medical Center, Petersburg
- Providence Alaska Medical Center, Anchorage
- Providence Kodiak Island Medical Center, Kodiak
- Providence Seward Medical Center, Seward
- Sitka Community Hospital, Sitka
- Valdez Community Hospital, Valdez
- Wrangell General Hospital, Wrangell

#### Alaska Center for Rural Health (the State's designated Office of Rural Health)

#### Alaska Department of Health and Social Services

- Commissioner's Office
- Division of Public Health
  - Director's Office
  - Section of Community Health and Emergency Medical Services
  - Section of Public Health Nursing
  - Medicaid Services Unit
- Division of Medical Assistance
  - Director's Office
  - Section of Health Facilities Licensing and Certification
  - Medicaid Rate Advisory Commission

#### Alaska State Medical Association

#### Alaska State Medical Board

#### PRO-West (the State's Peer Review Organization)

#### Alaska Nurse Practitioner Association

#### Alaska Family Practice Residency Program

#### Alaska Primary Care Association

#### Anchorage Neighborhood Health Center, Anchorage

#### Executive Director, Eastern Aleutians Tribe

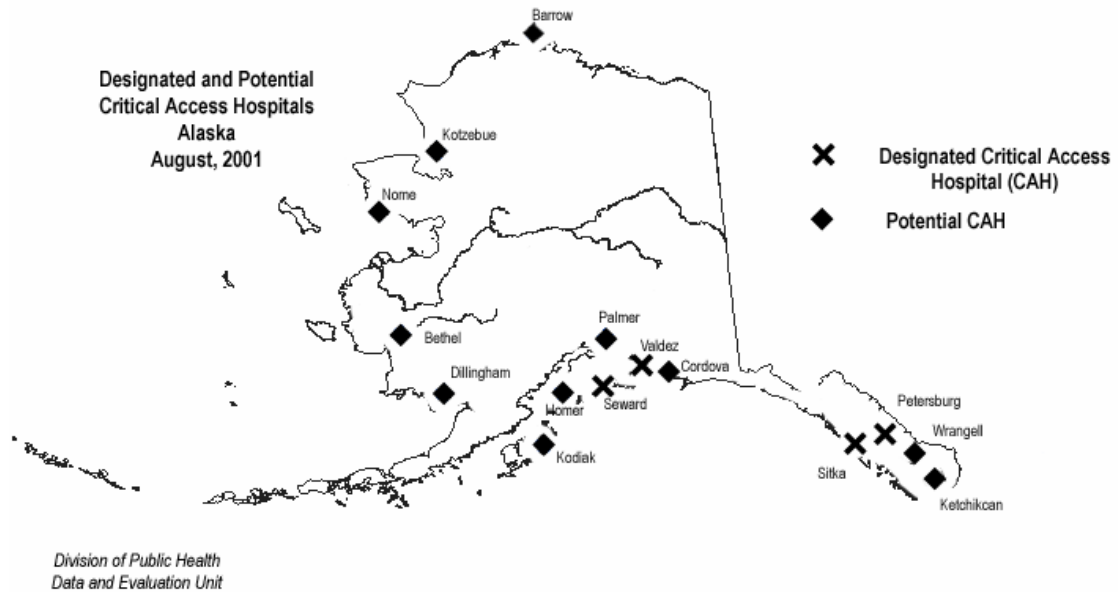
#### Health Care Financing Administration (Central Office and Region X)

### Appendix B. Alaska Health Professional Shortage Areas

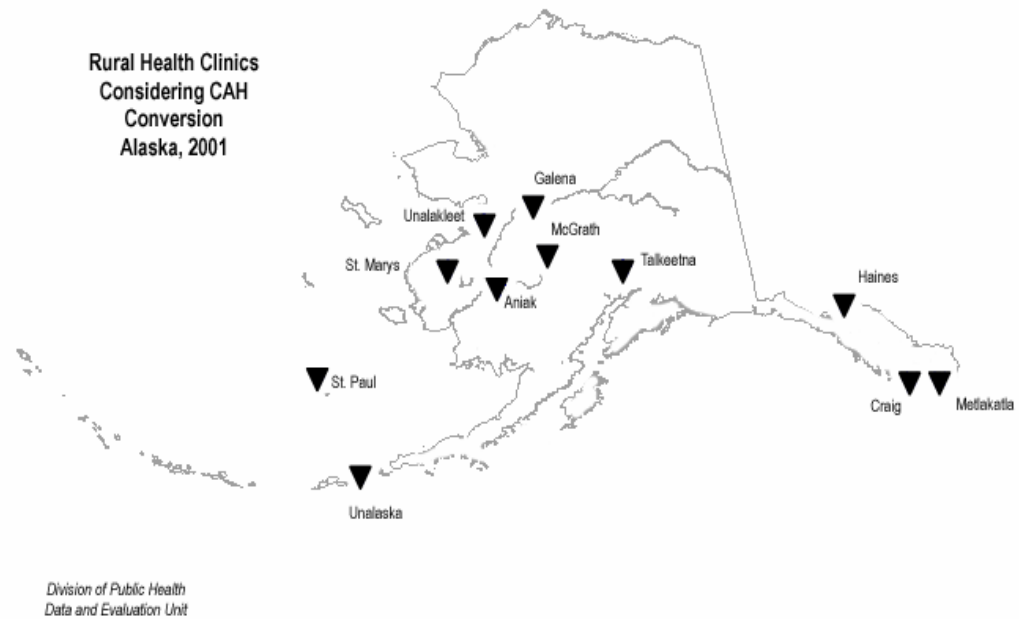
Location:	Primary Care	Mental Health	Dental Health
Aleutians East Borough	Yes	Yes	Yes
Aleutians West Census Area	Yes	Yes	Yes
Anchorage (North Census Tracts)	Yes		Yes
Anchorage AK Native Population	Yes		
Bethel Census Area	Yes	Yes	Yes
Bristol Bay Borough	Yes	Yes	Yes
Denali Borough		Yes	Yes
Dillingham Census Area	Yes	Yes	Yes
Fairbanks NSB (Low Income Pop)	Yes	Yes	Applied
Haines Borough	Yes	Yes	
Juneau Borough			
Kenai Peninsula Borough	Yes		
Ketchikan Gateway Borough	Yes	Yes	
Kodiak Island Borough	Yes		
Lake and Peninsula Borough		Yes	Yes
Matanuska-Susitna Borough	Yes	Yes	
Talkeetna/Trapper Creek			Yes
Nome Census Area		Yes	
Norton Sound			
North Slope Borough		Yes	Yes
Northwest Arctic Borough		Yes	Yes
Palmer Correctional Cntr	Yes		
Prince of Wales-Outer Ketchikan		Yes	
Sitka Borough	Yes		
Skagway-Hoonah-Angoon CA		Yes	Yes
Southeast Fairbanks Census Area	Yes	Yes	Yes
Valdez-Cordova Census Area	Yes	Yes	
City of Whittier	Yes		
Wade Hampton Census Area		Yes	Yes
Wrangell-Petersburg Census Area	Yes	Yes	
Wrangell Sub-Census			
Yakutat Borough	Yes	Yes	Yes
Yukon-Koyukuk Census Area	Yes	Yes	Yes

Applied - Application at Division of Shortage Designation, pending review  
 Revised January 2002

### Appendix C: Map of Designated and Potential Critical Access Hospitals



### Appendix D. Map of Rural Clinics Considering Critical Access Hospital Designation



## **Appendix E. Critical Access Hospital Designation Process**

### **1. Overview**

Conversion to a CAH under the Medicare Rural Hospital Flexibility Program requires that a hospital first be designated and then licensed by the State and certified by the federal government. The licensure and certification process for CAHs is essentially the same as the process for licensure and certification of other types of providers -- upon request from the provider, an on-site survey is conducted by Health Facilities Licensing and Certification staff to determine whether the facility meets applicable State and Federal law and regulations. If these requirements are met, the facility is licensed and certified to provide health care services (the State licenses health care facilities under its own authority and is delegated responsibility by the federal government to determine consistency with federal rules). The Medicare Rural Hospital Flexibility Program requires an additional step in this regulatory process -- "designation" by the State that the hospital is eligible to participate in the program and convert to a CAH.

This section of the Rural Health Plan summarizes the designation process and criteria for designation. Details in this Appendix will be updated periodically.

### **2. Identification of Interested Hospitals**

After a slow start-up, Alaska's experience is that all small, rural hospitals are interested in analyzing the potential financial effect of conversion to a CAH. In addition, a few hospitals that may be currently too large to qualify for CAH status, but are critical access points for their communities and are experiencing financial or recruitment problems and low census, also have some interest in examining participation in the program.

Because of its small population and lack of concentrated population centers, the State of Alaska has relatively few acute care hospitals, most of which are small and already provide limited services. Twenty-four hospitals are located in the State, including six hospitals operated by Native Corporations and two military hospitals. Like rural hospitals across the country, many of Alaska's rural hospitals are experiencing low inpatient volume (even in relation to their bed sizes) that is likely to continue to decline.

### **3. Application for CAH Designation**

A hospital that wishes to be designated as a CAH is required to submit an application to Health Facilities Licensing and Certification. Application forms are provided to hospitals that have expressed interest in CAH conversion, either formally (e.g., submission of a letter of intent) or informally (e.g., a telephone call). The application form is available at [http://health.hss.state.ak.us/dma/hflc\\_cah.htm](http://health.hss.state.ak.us/dma/hflc_cah.htm).

#### **4. Certification as a Necessary Provider of Health Care Services**

The federal legislation authorizing the Rural Hospital Flexibility Program requires that a CAH be more than a 35-mile drive (or in the case of mountainous terrain, or in areas with only secondary roads, a 15-mile drive) from a hospital or be certified by the State as a “necessary provider of health care services” to residents of the area. This provision of the law is intended to limit participation in the program to hospitals that are essential points of access to a community or to parts of a community that are unable to readily access services at other facilities. The State of Alaska agrees that the focus of the program should be on hospitals that meet health care needs that cannot be easily met by other facilities due to distance and/or other factors. The State will certify a hospital as a “Necessary Provider of Health Care Services” if it meets the following criterion:

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As discussed above, every non-federal, non-Native rural hospital in Alaska is at least 35 miles from another non-federal, non-Native hospital. However, Sitka General Hospital, a public facility located in Sitka, is only about two miles from Mt. Edgecumbe Hospital, a facility owned and operated by the SEARHC, a corporation formed to provide hospital and other health care services to Alaskan Natives in the southeastern part of the State. Service at SEARHC Mt. Edgecumbe Hospital is limited to Alaska Natives and other Native Americans and is not routinely available to other members of the community. As a result, Sitka General Hospital meets the criterion for certification as a Necessary Provider of Health Care Services.

#### **5. Network Development**

The State of Alaska strongly supports the intent of the Program to foster network development. While all rural hospitals in Alaska participate in networks at least informally, the State believes that formal membership in a network will be critical for all CAHs. As a result, network membership is mandated for these CAHs, as detailed above.

#### **6. Progress To Date**

Four rural hospitals have now been designated as CAHs. Six others are currently engaged in the process of analyzing the potential effects of conversion. The two remaining candidate hospitals have indicated an interest in receiving technical assistance and funding to conduct analyses of the potential effects of conversion.

The Federal Office of Rural Health Policy suggests including, at a minimum, all hospitals with an average daily census of seven or less, and those that have an operating margin of less than 2%, as candidate hospitals. Candidate hospitals are likely to consider conversion, and will need



support over the next three years as they consider this option. Many of the candidate hospitals listed in Table IV may consider downsizing licensed (but under-utilized) acute beds to 15, the threshold for CAH eligibility. Appendix C includes a map of current and potential CAHs in Alaska.

Some of Alaska's larger and better- equipped rural health clinics are now considering CAH conversion. Many of these sub-regional clinics are already staffed with mid-level providers, offer emergency services around the clock, and receive regular visits from a supervising physician. Some maintain an inpatient bed, and others keep patients overnight or longer when transfer to another facility is not possible. Clinics in Metlakatla, Unalaska, Talkeetna, McGrath, Galena, Klawock/Craig, and Haines may eventually opt for CAH conversion, and discussions have begun or about to begin in these communities (see map in Appendix D). The physical plant requirements for certification as a hospital is the main barrier to conversion for these clinics.

## Appendix F. Letter of Approval of Alaska Rural Health Plan



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care  
Financing Administration

Region X  
M/S 40  
2201 Sixth Avenue  
Seattle, WA 98121

August 11, 1998

Karen Perdue, Commissioner  
Department of Health and Social Services  
State of Alaska  
P. O. Box 110601  
Juneau, Alaska 99811-0601

Dear Commissioner Perdue:

I am pleased to inform you that your Rural Health Plan and request to participate in the Medicare Rural Hospital Flexibility Program (MRHFP) are approved. Your plan satisfies the requirements of Section 4201 of the Balanced Budget Act of 1997 (P.L. 105-33) in providing necessary Plan assurances and additional information. Your staff has provided the information needed to help us understand the Plan and its implementation.

We recognize that the MRHFP portion of your Plan describes a process for selecting critical access hospitals (CAH) and that you are to the point of identifying hospitals that may convert to CAH status. For this process to be successful, you will need to amend your Plan when hospitals are identified for transition to CAH status. At that time, please submit your amendment to the regional office and identify both the CAH(s) and acute care hospital(s) involved. Also please indicate who retains copies of all agreements identified in legislation (e.g., transfer agreements).

We encourage you to contact both the hospital's fiscal intermediary (FI) and the state survey office at that time to begin planning for completion of the HCFA-855 enrollment form. If the hospital meets the Plan requirements, plan to schedule an on-site survey at a time corresponding to the FI's completion of enrollment. Working simultaneously with both groups should expedite the conversion process.



Karen Perdue, Commissioner  
Page 2  
August 11, 1998

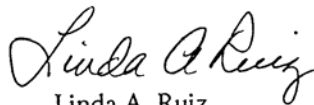
You will need to ensure that all selected hospitals satisfy the acute and swing beds limits that are allowed for a CAH. We note on page 20 of your Plan that the list of potential CAHs includes four hospitals that now have more than 25 total beds.

Finally, the question of whether "clinics" can be included in your Plan remains a point of discussion. As you know, we are working with HCFA policy and legislative staff to establish possible criteria that might allow physician clinics or rural health clinics in Alaska only to convert to CAH status. At this time, it appears that a legislative proposal will be needed to allow non-hospital clinics to become critical access hospitals.

We remain available to assist in the implementation of the Plan and in the transition of hospitals. Your Program Advisory Committee appears to be a continuing point of contact with the state and the regional office. If arrangements can be made, we can join the Committee meetings through conference call linkage.

If there are questions about this letter, you may contact Jim Underhill (206-615-2394), David Kerschner (206-615-2323), or Linda Ledbetter (206-615-2313). We are excited about the opportunity to partner with you in this effort to maintain a viable health delivery system that best addresses Alaska's unique issues.

Sincerely,



Linda A. Ruiz  
Regional Administrator

cc: Linda Ledbetter  
David Kerschner