

## Alaska State Health Care Environment 2015

### **New Federally Qualified Health Center Access Points in Alaska**

In 2015, Health Resources and Services Administration (HRSA) awarded New Access Point Grants (additional clinic sites) to the following existing Section 330 grantees: Aleutian Pribilof Islands Association; Dena'Nena'Henash (TCC); Kodiak Area Native Association; Peninsula Community Health Services; and Southcentral Foundation. Also, in 2015 Girdwood Health Center became a New Start Clinic. This brings Alaska's total Federally Qualified Health Center (FQHC) count to 29 managing organizations and approximately 168 clinic sites.

### **Affordable Care Act (ACA) in Alaska**

**Marketplace:** During 2015 open enrollment, 20,897 Alaskans enrolled for health insurance plans through the federally-facilitated Health Insurance Marketplace.<sup>1</sup>

**Medicaid Expansion and Redesign:** On July 16, 2015 Governor Bill Walker announced his intention to accept additional federal and Alaska Mental Health Trust Authority (AMHTA) funds to expand Medicaid in Alaska. It is anticipated that expansion will bring \$146 million to the state in its first year and extend coverage to well over 20,000 people.<sup>2</sup> AMHTA has agreed to fund the first year of the administrative costs of the expansion. The new eligibility categories include single adults earning up to \$20,314 per year or less, and married couples with a combined income of \$27,490 per year or less. It is anticipated that people who could qualify in these new categories will be able to apply beginning in September 2015. It is projected that 21,000 will sign up in the first year.<sup>3</sup>

The Department of Health and Social Services (DHSS) has been working on reforms to improve the Medicaid program. These initiatives include improvement to fraud and abuse controls, pharmacy reform, and care management to address the issues of super users of emergency room services.<sup>4</sup> DHSS has engaged a contractor to provide technical assistance and support for Medicaid expansion and redesign. The reform strategy is intended to facilitate development of a sustainable Medicaid program that: "optimizes enrollee health outcomes and access to care; drives increased value (quality, efficiency, and effectiveness) in the delivery of services; and provides cost containment in Alaska's Medicaid budget." The contractor, with feedback and assistance of stakeholders across the state, will conduct a Medicaid Reform Environmental Assessment that will address several aspects of this initiative. It will provide a description and

---

<sup>1</sup> Open Enrollment Week 13: February 7, 2015 - February 15, 2015. Available at:

<http://www.hhs.gov/healthcare/facts/blog/2015/02/open-enrollment-week-thirteen.html>

<sup>2</sup> Next Steps on Medicaid Expansion Announced. Press Release. July 16, 2015. Available at:

<http://gov.alaska.gov/Walker/press-room/full-press-release.html?pr=7229>

<sup>3</sup> Healthy Alaska Plan. Available at: <http://dhss.alaska.gov/HealthyAlaska/Documents/Medicaid-Fact-Sheet.pdf>

<sup>4</sup> Medicaid Redesign. Summary. Available at:

[http://dhss.alaska.gov/HealthyAlaska/Pages/Medicaid\\_Redesign.aspx](http://dhss.alaska.gov/HealthyAlaska/Pages/Medicaid_Redesign.aspx)

analysis of national factors impacting Medicaid programs and will also include discussion about other states' efforts and experiences with Medicaid health care delivery and payment restructuring. Additionally, all federal Medicaid financing authorities that may be useful in the redesign will be identified. The assessment will also address how these matters influence Alaska Medicaid redesign and will include all of the reform initiatives already underway in DHSS. The contractor will then assemble a report on Recommended Medicaid Expansion and Reform Strategies for Alaska. This will be ready for presentation to the 2016 Alaska Legislative Session. The final developed strategy will include a three-year action plan for implementing the recommended expansion model and reforms, as well as a plan that can be used to monitor and evaluate the results of expansion and reform initiatives in Alaska.<sup>5</sup>

***ACA Implications for Non-Profit Hospitals:*** In an effort to stimulate a continuum of community health, provisions in the Affordable Care Act require tax-exempt hospital facilities to conduct tri-annual community need health assessments. Non-profit hospitals have long been required to document the provision of community benefit in order to maintain their legal status for exemption from federal income tax under 501(c) 3 f the Internal Revenue Code. The ACA added a new 501(r) 3 to the Internal Revenue Code, establishing a set of expanded obligations as a condition for this status that the intent of this change is to ensure that non-profit hospitals are looking at the broader health conditions of community, and identifying and acting to improve their role in improving the community's health status.

In order to be in compliance, non-profit hospitals must do the following:

1. Define the community to be served
2. Conduct a community health needs assessment every three years.
3. Solicit community input from people representing the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
4. Document the findings of the assessment, including the prioritization of the findings for action.
5. Make the CHNA report widely available to the public
6. Adopt and report annually on an implementation strategy to meet the community health needs identified through such assessment.

### **Patient Centered Medical Home (PCMH)**

As of September 2015, there are 18 organizations in Alaska that are recognized as PCMH, through National Committee on Quality Assurance (NCQA), Joint Commission, or Accreditation Association for Ambulatory Health Care (AAAHC). Patient centered medical home (PCMH)

---

<sup>5</sup> Medicaid Redesign and Expansion Technical Assistance Standard Agreement. Available at: <http://dhss.alaska.gov/HealthyAlaska/Documents/0615-107-StandardAgreementFullyExecuted.pdf>

projects involving the Department of Health and Social Services over the past five years include the Alaska Patient Centered Medical Home Initiative, the Tri-State Children's Health Improvement Consortium, and the Pediatric Medical Home "D70" State Implementation Grant.

The purpose of the Alaska PCMH-I is to increase implementation of the PCMH practice/delivery model among Alaskan primary care providers. In 2014, the Alaska Mental Health Trust Authority granted the Alaska Primary Care Association \$500,000 to supplement a \$437,500 capital appropriation from DHSS to create the Alaska PCMH-I with the aim of furthering PCMH transformation among several CHCs and other primary care providers over the next 5 years.<sup>6</sup> The APCA assists clinics in achieving transformation through readiness assessments, action planning, and ongoing learning sessions. The 2014 Alaska PCMH-I (Phase I) ends November 2015, with all participating sites expected to be PCMH recognized or accredited. Ongoing monitoring of the practices is scheduled through 2019.

The Tri-State Children's Health Improvement Consortium (T-CHIC) was a CHIPRA demonstration project managed by DHSS Division of Public Health, Section of Health Planning and Systems Development and funded by US DHHS Centers for Medicare and Medicaid. The Medical Home Office Report Tool (MHORT) was used to track practices' achievement of PCMH competencies. Between 2012 and 2014, Alaska's three TCHIC practices improved an average of 10 percentage points in patient-centered medical home competencies for all patients and 14 percentage points in efforts specifically targeted to children and youth with special health care needs.

The Consumer Assessment of Healthcare Providers-Clinicians and Groups PCMH (CAHPS-CG PCMH) survey for children and adults was fielded in 2012 for the TCHIC clinics and in 2014 expanded to include other Alaska PCMH-I or Title V partners. This survey begins to standardize the patient experience survey work among community health centers and pediatric practices. With support from Title V funding, TCHIC contracted with the Alaska Primary Care Association in 2015 to assist clinics with PCMH recognition and facilitate a learning collaborative to support clinics in improving their CAHPS-CG PCMH outcomes.

The DHSS Division of Public Health Section of Women's, Children's and Family Health has specifically focused on PCMH model access for children and youth with special health care needs and condition (CYSHCN) since 2011. Their current federal grant award (2014-2015) seeks to expand on successes of their Pediatric Medical Home "D70" State Implementation Grant, including a Pediatric Care Coordination curriculum with University of Alaska and the CAHPS-CG PCMH survey partnership. The overarching goal of the current three year project is to integrate services for CYSHCN as measured by increasing the proportion of Alaska families

---

<sup>6</sup> The project period for the 2014 funding ends in 2019.

reporting access to the PCMH model by 20%. Current work is being framed in a nationally defined context of “systems integration” as facilitated by the National Academy of State Health Policy (NASHP) and HRSA. Alaska partners have chosen to focus on integration strategies related to behavioral health and primary care, as well as continued efforts to expand sustainable care coordination into clinical practice.

### **Medicare/Medicaid**

Medicare covers approximately 82,000 Alaskans including 65,600 people who are 65 or older and 16,400 who are younger than 65 and disabled, people with end stage renal disease or Lou Gehrig’s disease. Beginning on October 1, 2014 Centers for Medicaid and Medicare (CMS) changed their payment methodology for Medicare claims for FQHC’s, transitioning to a prospective payment system (PPS) in which Medicare payment is made based on a predetermined, fixed amount. All health centers will have transitioned to this new system by December 31, 2015. All FQHC organizations are working to understand and effectively implement the new system by setting up new “G” codes, determining appropriate pricing, and working with their Practice Management vendor to accurately submit claims. This change is expected to have a positive effect on reimbursement rates for services provided to Medicare beneficiaries, if set up correctly.

Alaska’s Community Health Centers play a vital role in providing services to Medicare beneficiaries who otherwise may not be able to identify a healthcare provider that is enrolled to bill Medicare. This access to care crisis is exacerbated by a relatively young working population covered by employer group health coverage that pays higher reimbursement rates than Medicare, lack of a medical school in Alaska, a shortage of Primary Care providers statewide and a growing aging population placing higher demands on a shrinking and aging physician workforce.

Medicaid: In the fall of 2013, Enterprise, a Web-based claims processing system, went live and was quickly determined to have significant issues. The previous claims processing system, in place for 25 years, processed an average of \$27 million in claims each week. During its first weekly cycle, Enterprise processed a total of just over \$10 million in claims. Over the next several months, hundreds of defects and issues were identified in the system. Many providers suffered the financial consequences of these issues and the state was forced to provide interim payments to those who were most adversely affected.

Due largely to the efforts and direction of division staff working long hours side-by-side with Xerox, Enterprise has turned a corner. Current Medicaid claims production cycles process an average of 108,000 claims for an average of \$29.5 million dollars each week. There are currently just 68 known defects, and Enterprise is processing and suspending claims correctly at the highest rate of any time since the system went live. Interim payments are no longer being requested and providers have begun repayment of the provisional financial support provided by the state.

Currently there are no proposed changes to the Denali Kidcare/Child Health Improvement Program (DKC/CHIP).

### **Behavioral Health**

In FY14, the Division of Behavioral Health (DBH) conducted a survey to assess the current level of integration of primary care into Community Behavioral Health Centers (CBHC). Several CBHC's are also FQHCs. The survey findings highlighted numerous advantages to integration, but the number of identified barriers has greatly hindered CBHC/FQHC integration efforts. Since the survey, DBH has developed technical assistance to assist agencies with integration, and DBH has been strongly advocating for agencies to develop integrated care models. In addition, DBH continues to develop internal strategic goals and draft supporting regulatory structure to break down barriers and open doors for integrating primary care and behavioral health. The *Alaska Behavioral Health- Primary Care Survey Report Results* can be found on the DBH website under Announcements at the following link: <http://dhss.alaska.gov/dbh/Pages/>

### **Veterans**

The Veterans Administration (VA) and Indian Health Services have entered into a [sharing agreement](#) that allows tribal health organizations to agree to participate in and receive reimbursement for providing service to veterans. The VA is developing agreements with non-tribal delivery sites (community health centers) also. The VA's introduction of the Choice program health care option administered by TriWest is a new factor in accessing health care for Alaska Veterans. Potentially there will be changes in the program's use in Alaska and the Alaska Veterans Health Care System is the point of contact for information and updates.

Additional sources of care for rural veterans in Southeast Alaska are provided through the Rural Veterans Health Access Program (RVHAP), funded by HRSA's Office of Rural Health Policy and administered by the State Division of Public Health. The RVHAP's purpose is to provide telebehavioral health and teleprimary care at some sites for veterans and their families and others in remote rural areas. There are four partnering agencies with a total of seven service sites. Teleconnectivity for video-linked consults has been established in all seven sites and services are available with links to clinicians in the hub communities of Juneau, Wrangell and Sitka. The RVHAP has also sponsored a series of educational webinars in August 2015 for medical and behavioral health clinicians and the public on Traumatic Brain Injury and for community members on 'first responder' Suicide prevention. Both of these are significant health issues for veterans and the RVHAP has addressed the need for information and training through these events.

### **Meaningful Use and Health Information Exchange (HIE)**

The electronic health record incentive program has been making payments to hospitals and providers that have qualified for payment under meaningful use since 2011. In Alaska, Eligible

Hospitals (EH) and Eligible Professionals (EP) have received payment to Adopt, Implement, and Upgrade (AIU) Electronic Health Records (EHRs) and for Meaningful Use (MU) of EHRs. As of July 2015, 749 Eligible Professionals have been paid for AIU and 405 have been paid for Meaningful Use. Total payments made to EPs are \$19,329,033 thus far. There are 21 Eligible Hospitals that are registered with the state, and payments to those hospitals for AIU and MU total \$23,495,501.

The Alaska HIE, which is operated by the Alaska eHealth Network, went into live production in June 2013. Currently 20 hospitals have signed contracts with AeHN to become users of the HIE, 8 of which are currently live. The remaining 12 are expected to be fully onboarded to the HIE by the end of calendar year 2015. Three additional hospitals are in process of reviewing contracts and it is expected that they will sign. This encompasses over 550 individual users. There are 41 clinics that have contracted with AeHN for HIE services. Additionally, there are three public health registries that are connected to the HIE including electronic labs, syndromic surveillance and immunizations.

### **Legislation related to Telehealth**

No new legislation was passed regarding telehealth during the 2015 legislative session, but it was an area of focus. Proposed changes in the areas of Medicaid reform, Medicaid expansion, health care delivery and cost containment all included discussion around the use of telehealth to improve access and reduce costs. Primary care, behavioral health and urgent care were particular areas of interest in considering the expansion of the use of telemedicine.

### **Alaska Vaccine Assessment Program (AVAP)**

The Alaska Vaccine Assessment Program (AVAP) was authorized in the 2013-14 legislative session to improve access and reduce costs, and was successfully launched January 1, 2015. Through AVAP, the State DHSS receives funds from insurers and other payers and provides vaccines at a reduced cost through its bulk purchase. In 2015, the state is able to provide all recommended vaccines to insured children and selected adult vaccines to clients of participating payers through AVAP. AVAP is funding vaccines for nearly 80,000 children and 290,000 adults. Providers who have questions about AVAP or state supplied vaccine can e-mail [immune@alaska.gov](mailto:immune@alaska.gov) or visit [www.epi.hss.state.ak.us/id/immune.stm](http://www.epi.hss.state.ak.us/id/immune.stm) or [www.AKvaccine.org](http://www.AKvaccine.org).

### **State Primary Care Needs Assessment**

Alaska's PCO is in the process of conducting a statewide primary care needs assessment. The assessment will include key informant interviews; a statewide grid by census area of selected health care access factors and health indicators; Census Area "snapshot" of health access indicators and health factors; statewide survey of all primary care, behavioral health and dental providers, and an in-depth analysis of gaps in service and workforce issues.

### **Implementation of New National Shortage Designation Management System (SDMS)**

The State Primary Care Office is in process of updating Alaska's National Practitioner Index Database as this will populate the new SDMS to be used to create and renew Health Professional Shortage Area (HPSA) and Medically Under-served Populations/Areas (MUAs/MUPs). This project involves obtaining selected information about all primary care physicians, psychiatrists, and dentists currently practicing in the state. Alaska currently has 213 HPSAs (including "auto for facility-HPSAs). When the new SDMS becomes operational in 2016, it is imperative that Alaska's database be accurate to avoid the potential of losing HPSAs.

### **Workforce- Loan Repayment and Incentive Pay**

One of the roles of the Alaska Primary Care Office in the DHSS Division of Public Health Section of Health Planning and Systems Development is to manage and coordinate programs to recruit and retain health care professionals to serve in healthcare shortage areas. These programs include SHARP, National Health Service Corps, HRSA Nurse Corps, and J1 Visa/Conrad 30.

Alaska's SHARP Program addresses the shortages and mal-distributions of certain health professionals in the state by increasing the number and improving the distribution of healthcare professionals who provide direct patient care. The SHARP program seeks to recruit and retain selected health care professionals to serve in designated healthcare shortage areas in exchange for the repayment of qualifying education loans and/or payment of direct incentive. SHARP provides clinician-specific support (either loan repayment or direct incentive), which is resourced via blended funding, from several sources. As of July 2015, Alaska's SHARP Program has provided support-for-service to 194 practitioners, with current field strength at 118.

SHARP practitioners work in medical, dental and behavioral health occupations, in all regions of Alaska. To date, over 60 healthcare agencies have participated, with clinicians practicing in highly varied settings: community health centers, hospitals, community behavioral health centers, varied clinics, most tribal health organizations, the Department of Corrections, and Alaska Psychiatric Institute, amongst others.

SHARP has two components, SHARP-I and SHARP-II, with both now scheduled through 2018. SHARP-I is our traditional HRSA-SLRP partnership grant, the purpose of which is to recruit and retain selected primary health care professionals to serve in federally designated Health Professional Shortage Areas (HPSA) in exchange for the repayment of qualifying educational loans. SHARP-II is funded wholly by non-federal sources, and thus includes a broader range of settings and disciplines.

To date, SHARP has provided \$7,464,107 in clinician support for service. This now also includes required partial employer match (25% ca), with \$826,414 garnered thus far. SHARP has just passed its 5-year milestone, with its first clinicians having begun on 6/10/10.

The [National Health Service Corps \(NHSC\)](#) offers tax-free loan repayment assistance to support qualified health care providers who choose to take their skills where they're most needed. Licensed health care providers may earn up to \$50,000 toward student loans in exchange for a two-year commitment through the [NHSC Loan Repayment Program \(NHSC LRP\)](#). Health professionals participating in the NHSC LRP may serve as primary care medical, dental, or mental/behavioral health clinicians at an approved NHSC site. Accepted participants must find a position at an NHSC-approved site and fulfill a 2-year commitment. Grantees may choose to serve longer for additional loan repayment support.

As of June 30, 2015, there were 55 clinicians in Alaska receiving loan repayment from the National Health Service Corps and 6 from the [HRSA Nurse Corps program](#). In addition, 3 National Health Service Corps scholarship recipients were working in underserved areas.

Medical students (MD or DO) may earn up to \$120,000 in their final year of school through the Students to Service Loan Repayment Program (S2S LRP). Students must commit to serving either 3 years full-time or 6 years part-time at an NHSC-approved site with a Health Professional Shortage Area (HPSA) score of 14 or higher.

Alaska's [J-1 Visa Conrad 30 Waiver program](#) enables the state health department to find that it is in the public interest for a foreign medical graduate to be hired for a hard-to-fill position that provides care to an underserved population. Up to 30 J-1 physicians are allowed per year under the J-1 Visa Conrad 30 program. Additionally, under the J-1 Visa Conrad 30 "Flex 10" option, up to ten J-1 physicians annually can work in a medical facility that is not located in a health professional shortage area but that serves residents of shortage areas.

## **Links to Useful Sources of Data for Grant Applications**

**Alaska Bureau of Vital Statistics:** <http://dhss.alaska.gov/dph/VitalStats/Pages/data>

Rates by borough/census area, Native Regional Corporation, statewide

- Low birth weight
- Infant mortality rate
- Suicide rate
- Age-adjusted death rate
- Cardiovascular disease mortality rate
- Births to teenage mothers
- Unintentional injury mortality rate

**Alaska Center for Health Data and Statistics – Informed Alaskans:**

[http://dhss.alaska.gov/dph/InfoCenter/Pages/ia/brfss/brfss\\_health\\_profiles.aspx](http://dhss.alaska.gov/dph/InfoCenter/Pages/ia/brfss/brfss_health_profiles.aspx)

Rates by borough/census area, Native Regional Corporation, metropolitan/micropolitan statistical areas, public health regions, statewide; crude rates and age-adjusted rates

- Cancer screenings
- Dental visits
- Diabetes
- High blood pressure
- Asthma
- Adult obesity
- Flu shots
- Health plan coverage
- Tobacco use
- Binge drinking

**Alaska Department of Labor:** <http://laborstats.alaska.gov/>

- Population by borough/census area
- Percent elderly population

**Alaska Health Care Data Book: Selected Measures (2013):**

<http://dhss.alaska.gov/dph/HealthPlanning/Pages/publications/healthcare/default.aspx>

**Alaska Scorecard: Key Issues Impacting Alaska Mental Health Trust Beneficiaries:**

<http://dhss.alaska.gov/dph/HealthPlanning/Pages/scorecard>

**Affordable Care Act – Alaska-specific studies on Medicaid gap**

- [http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen\\_Medicaid\\_Expansion\\_Analysis-020615.pdf](http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf)
- [http://dhss.alaska.gov/Documents/Lewin\\_Final\\_Report.pdf](http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf) (2013)
- <http://www.anthctoday.org/news/Medicaid%20in%20Alaska%20Under%20the%20ACA%20Final.pdf> (2013)
- <http://www.anthctoday.org/news/Final%20Report-Fiscal%20and%20Economic%20Impacts%20of%20Medicaid%20ExpansioninAlaska.pdf>.
- <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>

**Healthy Alaska Plan (Medicaid Redesign):**

- <http://dhss.alaska.gov/HealthyAlaska/Pages>

**Section of Health Planning & Systems Development – partner links:**

<http://dhss.alaska.gov/dph/HealthPlanning/Pages/resources>

**U.S. Census** (slightly more complicated to use)

- **American Community Survey:** <http://www.census.gov/programs-surveys/acs/>
- **American Fact Finder:** <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>